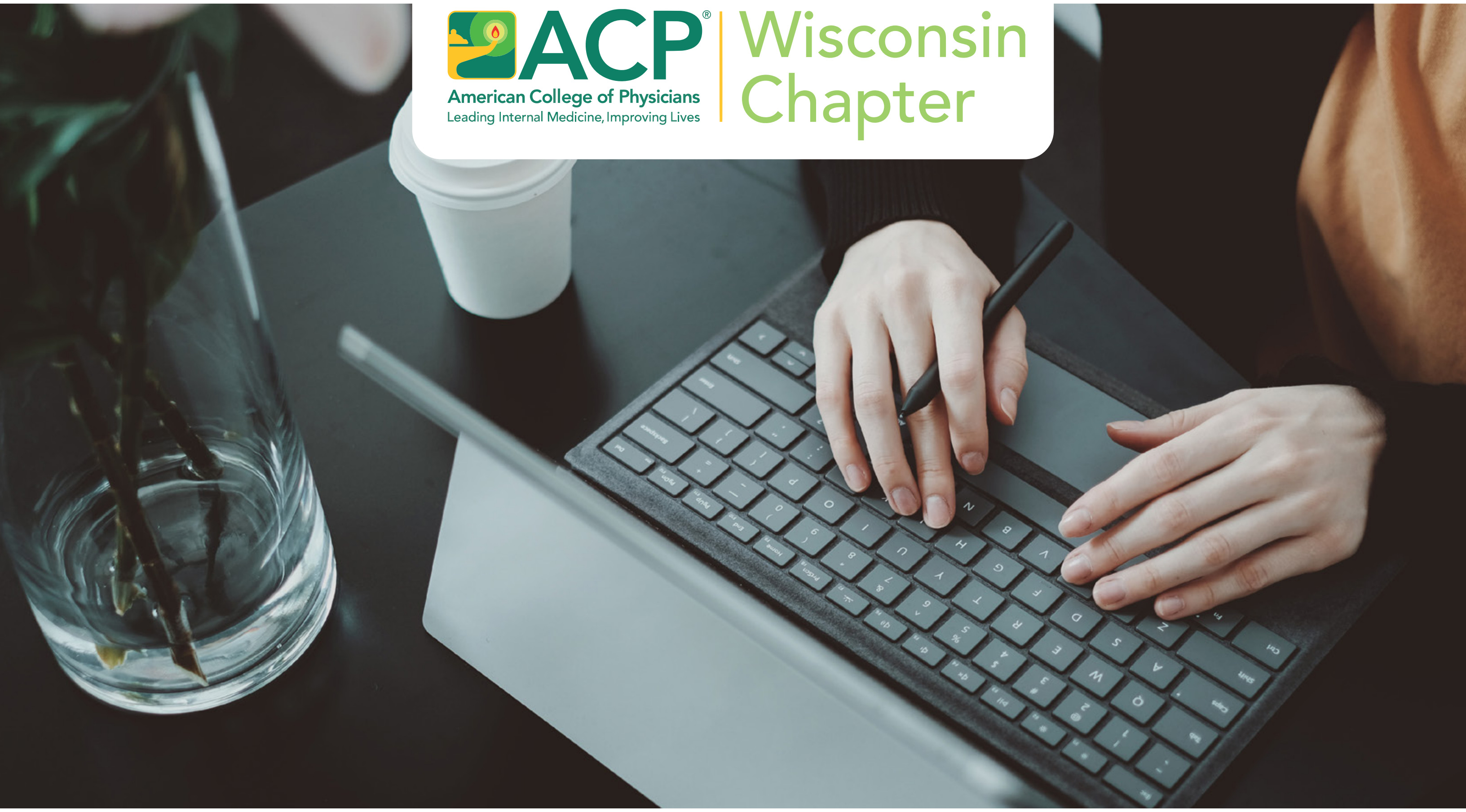
2025 NARRATIVE MEDICINE BOOKLET

ACP American College of Physicians
Leading Internal Medicine, Improving Lives
Wisconsin Chapter



Sponsored by the ACP-WI Women's Committee

The ACP Wisconsin Chapter recognizes the value of sharing struggles, triumphs, and everyday life as a way to foster a sense of meaning in medical practice. These written works remind us of the reasons we chose Internal Medicine, and why we continue practicing everyday. The pieces included in this booklet have been submitted by members across the state, at varying levels of practice, and reviewed by a panel of judges.

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Stay tuned for further Narrative Medicine events from ACP Wisconsin. If you would like to be more involved with Narrative Medicine with WI-ACP, email info@acpwi.org

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** Any patient identities have been masked; if a patient is able to be identified based on information in the piece, signed permission from the patient or patient's representative is has been acquired.*

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POETRY

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ESSAYS

1. A Small Breath

Evanka Annyapu

“We were both just staring at a baby in the nursery on a CPAP who was posturing and suffering from brain damage due to respiratory distress at only 5 days old. I remember the way her tiny chest rose and fell against the hiss of the machine, the sharp contrast between the fragility of her body and the heavy, unnatural sound of forced breath. My colleague, standing beside me in silence, finally whispered, ***“That’s the beautiful thing about kids; you can watch how they come back to life.”***

I hold my phone steady, as if it were my anchor to this moment, feeling a wave of something I couldn’t place a finger on, wash over me— grief? Or was it awe? I struggled to catch my breath even though the house gave me more than enough space. The rhythmic beeping of monitors in the nursery was the kind of quiet that hadn’t been peaceful, but full, like someone holding their breath. I felt quite small in the space and would fill any minute of silence with lyrics to music that I couldn’t make sense of.

It was the first time in a few weeks that I had really sat down to process my feelings. Far away, I could hear *Godspeed* by Frank Ocean play from the morning that I was driving back from shadowing overnight at the pediatric emergency department.

I will always love you

How I do

Let go of a prayer for you

Just a sweet word

The table is prepared for you

It was a song that echoed my thoughts and followed me through a thread of memories. That morning, I had imagined an entire storyline of a baby who stopped breathing on the side of the road. The baby didn’t make it to our hospital — maybe they made it to another one, maybe not. I would never know. But in my mind, I imagined their journey, and how close they were to disappearing before anyone knew their name. I thought about the people who loved them. I couldn’t help but sit longer with how a single breath changed a whole future.

And then I thought of the baby on the CPAP. How that moment felt significant to me at the time, and quietly, this baby’s resiliency was resounding.

What I saw in that one day at Mengo Hospital stuck with me. The suffering had been something you couldn’t turn off mentally; seeing another human struggling to breathe on their own while you were taking your own steady breaths. More importantly, it was the tiny flickers of determination and resilience in one of the most fragile patients you could encounter. The sacredness of this moment I had captured the table I hoped to prepare in my future career. A table that would serve as a beacon of hope for children whose worlds may feel overwhelmingly large and could fight back harder to be alive if someone can be patient and advocate for them.

It was in these moments, I find my thoughts bigger than the person I am.”

2. When Are You Coming Home?

Kristen Apolinario

"Mom, when are you coming home?" I whispered into the cordless phone, my five-year-old self hoping she would say "Right now."

"I'm not sure yet," she answered gently. "I have to deliver a baby."

"Well … when will it arrive?"

A family physician in a town of 2,100, she had already finished an 8-to-5 clinic day of well-child checks and blood-pressure follow-ups, then evening rounds on her hospitalized patients. Yet, the pager still dragged her back for a midnight delivery. Reflecting to those late-night phone calls, I learned early on that rural medicine runs on sacrifice — sleep, predictability, family milestones — but the debt is repaid in the health and gratitude of the people it looks after.

Our family story began an ocean away. Mom left the Philippines with a medical degree, 3 sons (my sister and I weren't around yet), and an unshakable conviction that healing should know no borders. Dad shelved his mechanical engineering career so us kids would always have one parent home while the other cared for everyone else's. Manila's diesel haze became wood smoke and silage; typhoons turned to blizzards.

Most days after elementary school, I would ask my dad to bring me to Mom's clinic, hoping to spend any minute I could with her between patients. I would sit quietly in the corner of her dimly lit office, and, each time the door would open, I would try to get glimpses of the steady parade of people who came to visit Mom. Who were all the people holding her here all day? I saw a lot of hugs, a lot of tears, and sometimes some people would drop in just because they needed to talk to Dr. Cruz. I began to understand why she stayed so late: the town's stories flowed through her door, and she held them with both hands.

By middle school I recognized how "different" our household looked. Curious classmates asked where I was *really* from or whether it felt odd that Mom worked so much while Dad was at home. To me, his role was just as monumental. While Mom stitched wounds in the ER, Dad gathered all five of us around the kitchen table, ladling *kanin* and *ulam* onto our plates and weaving tales of San Miguel, Bulacan — *Lola* and *Lolo* running their own clinic, accepting chickens or carabao milk as payment. Service, I learned, tied our family together, whether practiced in a tropical barangay or a snow-blanketed dairy county.

Years later, after I'd earned my own short white coat, I finally stood beside Mom at the Philippine Center Free Medical Clinic in Milwaukee — a community-center-basement-turned-clinic that felt like the crossroads of my childhood and my future. On this Saturday, she traded her rural practice for a community center basement and spent the day treating patients who shared her first language but lacked insurance. My job was to help organize medications; hers was everything else: providing hypertension counseling, inspecting swollen knees, coordinating care for uncontrolled diabetes. In those narrow rooms I watched Dr. Cruz in full flight, shifting languages mid-sentence and charting with the same steady hand that once tucked me into bed. The geography was new, but the instinct to serve had never moved an inch.

That day clarified the quiet arithmetic of rural medicine. Nearly one-third of Wisconsinites live in rural counties, yet barely one in ten physicians in Wisconsin practices there. A town of 2,100 can't support a parade of specialists, so the family doctor stretches to fill every gap. When the nursing home needs a medical director, she adds another pager; when a January whiteout shutters Highway 10, she is still the only lifeline. The scope is dizzying, and the cost is real — missed birthdays, children who drift to sleep beside the phone — but each sleepless night she logs keeps an entire county's worth of heartbeats within reach of care.

Near midnight in Milwaukee, bent over my laptop reviewing UWorld questions, my phone glows: *When are you coming home?* I picture Mom at her desk, thumb-typing between chart notes.

I text back, "I'm not sure yet" because I'm in the hospital that week. I laugh a little to myself — the question I once whispered at five is now hers. Duty still tugs us in opposite directions, yet every buzz of that screen reminds me we share the same refrain: **When are you coming home?**

My mom, Dr. Cruz, and I after our shift at the PCFMC

3. In His Being

Mahmoud Awad, MD

Say, doctor, you've got kind eyes—not just the color in them, but the way they hold still when you listen, how they hesitate just long enough before turning away, like you're trying to carry what I've said rather than just record it. My clock is ticking. I've signed the forms - DNR, DNI - and I know that's what brought you to my bedside today, but before this all fades, I need you to hear why.

Doctor, before we discuss the matter of endings, I'd like to tell you something about the in-between. I wasn't anyone special, not by this world's measure. But I built a life with my hands, calloused and cracked, crawling beneath sinks and into crawlspaces, fixing what was broken, even as something inside me quietly unraveled. For years, I thought meaning came from being useful, from being the one others leaned on, and I never quite learned how to lean back.

And, doctor, I had an empire once – not, like, one of wealth or headlines, but of Sunday mornings and shared meals, of scraped knees and first dances, of tools passed down and stories retold. My empire has collapsed now. There is a hollowness that betrays me. My hands, once so strong they could mend broken plumbing or cradle newborns, now tremble without warning. My voice is thin and unreliable, more whisper than statement.

Say, doctor, I think about God a lot these days - not the one painted on chapel ceilings or tucked into scripture, but the one that might be hiding in the permanent silence after heartbeats. I think maybe I've spent most of my life chasing something sacred without knowing its name, like a dog after the wind, never expecting to capture it, but compelled to run all the same. And now that my chase has slowed to a crawl, I wonder if that restless reaching, that yearning that never quite arrives, might be all faith ever really is.

But doctor, I just feel like a willow tree, grand but weary, stuck in the impossible choice between growing or breathing. In my dreams, I verge on prayer. I still feel my limbs stretch toward the sun, toward something warm and moving, but my roots are ever so dry and brittle, and the wind that once thrilled me now only rattles.

Doctor, I'm not afraid of death, not really. What frightens me is missing it - slipping out of this world unconscious, unaware. I want to be awake. I want to see it coming, not as a menace, but as a companion. And when it arrives, I want someone beside me who won't look away.

But, doctor, please understand: not all wounds want to be closed. Some, like, simply want to be seen. My wounds don't need fixing, just witnessing. When the chart is reviewed, when the next physician asks who I was, tell them I didn't ask for more time – tell them I asked for peace.

Say, doctor, there is still beauty here. In the way the nurse adjusts my blanket without being asked. In the way sunlight lands in little halos across my chest. I count those quiet mercies as they pierce me for one final time, soft as breath. They are the breadcrumbs that lead me somewhere kind.

Say, doctor, I can feel it now—the soft, slow coming of whatever is next. It is faint and familiar, like a song I used to hum but forgot I loved. And as I lie here, falling from the fiftieth floor, I linger on each balcony's bloom, savoring beauty. And the earth rises to claim its infinite son.

4. No Such Thing As a Routine Procedure*

Alenna Beroza

When I signed up for the Internal Medicine Procedures elective, it was mostly out of practicality. The two-week window fit neatly into my schedule, and it replaced a more time-intensive course that I wasn't really feeling drawn to anymore. I'd heard the elective was hands-on and a good opportunity to build procedural comfort – even if it was not necessarily in my field of interest, Obstetrics and Gynecology. So, I enrolled hoping to walk away with some technical skills and a smooth final stretch of third year.

And I did. I performed multiple paracenteses and thoracenteses independently. I assisted in lumbar punctures and sharpened my ultrasound skills. I was reminded that I feel most engaged during procedures – at the bedside, hands working, mind focused. In that sense, the elective reaffirmed that Ob/Gyn is the right path for me.

But what surprised me most about the rotation wasn't the procedures. It was the patients, and more specifically, the moments before the procedures.

On traditional inpatient rotations, I prided myself on being the well-prepared student. I knew my patients' full charts including every nursing note, diagnosis and MyChart message. I checked-in with families, returned multiple times to patient's rooms, and tried to get to know them beyond their diagnoses.

That felt like good patient care, and it was. But, I was rarely present for the uncomfortable in-between moments: the wait for a delayed scan, the unexpected poke in the middle of the night, or the fifteen minutes of silence before something unknown Those moments were usually someone else's responsibility – a family member, a nurse, a friend, or no one.

Procedures changed that. Our team spent at least 45 minutes with each patient, often more, simply by necessity. There was no strict schedule, no predictable flow, and no way to fully prepare in advance. We waited for referrals and for patients to become available. We adapted to hospital constraints. We overtook cramped spaces filling them with machines and movement. And as we prepared – completing paperwork, chasing down supplies, setting up sterile fields, and gowning up – our patients waited. Often alone. Surrounded by a flurry of clinical activity, but often no one who was just with them.

That's where I met "Jane."

She was a 44-year-old female referred for a paracentesis due to abdominal distention. There wasn't much charted history, but the whiteboard listed "Dr. L," a gynecologic oncologist, as the referring physician. That told me more than anything else. She hadn't been formally diagnosed yet, but I suspected what we all, except Jane, silently knew: she likely had ovarian cancer.

When we entered, her husband was there briefly before stepping out. As we began to prepare, Jane sat in her hospital gown with her hands in her lap, eyes darting around the room. She told us that she hadn't really been sick before. She thought she was just gaining some weight, until the bloating became painful. Her voice trembled.

The team swirled around her – residents checking supplies, the attending reviewing imaging and students setting up trays. Everyone had a job. And while the room buzzed with efficiency, Jane sat shaking, tears beginning to well in her eyes.

The bed hadn't been raised yet, so I crouched beside her, gently reached for her hand, and reintroduced myself. "It's okay to be nervous," I said. "I'll be right here."

She nodded, squeezed my hand, and took a breath.

Then, when the time came for the procedure to begin, she didn't look to the attending or the residents. She turned to me, "Can you be the one who does the procedure?"

That moment stopped me. This paracentesis – just another routine task for our team – was not at all routine for Jane. For her, it was terrifying. It was foreign. It was possibly the first step toward learning she had cancer. It reminded me that what feels like "just another procedure" to us – another signed consent, another fluid tap – is often one of the most pivotal, defining moments in a patient's life.

Medicine trains us to adapt, to streamline, to move efficiently, to see statistics. But when our routines eclipse our relationships, we lose something essential. We forget that our normal is someone else's upheaval. That our language – safe, sterile, rehearsed – is often not what our patients need most.

Jane reminded me that human connection is never a footnote to clinical care. It is clinical care.

As I prepare to enter my final year of medical school and look ahead to residency, I carry Jane's hand with me. I carry the responsibility to make space, to be still when needed, to witness fear and stay present through it. And, I carry the knowledge that every single procedure – no matter how routine for me – may be life-changing for the individual on the other side of the drape.

**All identifying information has been changed. The names included are not the actual names of the individuals in the story and no other identifying information is provided except the patient's age.*

5. Where Medicine Meets Humanity

Sara Bertan

“You punched our patient?”

I stared blankly at my attending as my heart sank to my stomach. In the few seconds of silence that followed, seconds that felt like an eternity, I scrambled to remember if I had possibly done something so unthinkable. Was he confusing me with someone else? Had I blacked out?

My whole career flashed before my eyes.

The silence broke with a grin.

“The patient was joking,” my attending clarified. “She told me, ‘That young doctor punched me in the back this morning.’”

Relief washed over me as I could finally catch my breath. The “punch” she referred to was a physical exam maneuver to assess for costovertebral angle tenderness. I had tapped lightly on her back to check for signs of a kidney infection. Though I had explained it beforehand, to the untrained eye, it may well have looked like a punch.

The next morning, I knocked on her door and joked, “I promise I’m not here to fight.”

She smiled and replied, “You’re the only one I let punch me before breakfast.”

From then on, it became our morning ritual; an inside joke that brought a bit of lightness to her difficult days. That moment, light as it was, added something important to our clinical relationship: a sense of humanity.

As her hospitalization stretched on, so did our bond. One morning, I noticed the gold cross around her neck and asked about her faith. She shared her beliefs, and in turn, asked about mine after seeing my own necklace. That simple exchange became another layer of care, one not charted in notes or dictated in plans.

In a hospital where patients are seen by countless teams and asked to repeat their story again and again, continuity becomes an anchor. It begins with small acts of noticing: a sense of humor, a necklace, a worry left unsaid. Yet in the rush of routines and busy workflows, we often desensitize ourselves to these small human details to focus on the big clinical ones, but even clinical routines can become relational. The “punch” we joked about became more than a physical exam maneuver; it became a moment of shared humor, a seed of trust. That bond allowed me to notice the subtleties, like a change in demeanor or the absence of morning banter, that no lab result can reveal. These small cues offered a window into my patient’s baseline beyond her illness. When she didn’t joke with me in the morning or seemed unusually withdrawn, I sensed something was off, often before labs or imaging showed it. Over time, those quiet recognitions build trust not through grand interventions but through consistent presence.

My few weeks with her shed light on the power of continuity in medicine. Though, it isn’t continuity alone that builds connection, but continuity combined with compassion, presence, and attention that makes it powerful. For us, it might be just another day at work; for our patients, it is often one of their hardest. However, even a brief connection formed over something as simple as a routine exam can transform that experience. Showing up again and again, even just to deliver that light “punch” becomes its own form of care.

In a system that often prioritizes efficiency and output, continuity can feel like a luxury, but I believe it’s essential. It creates space for trust, for advocacy, and for a kind of healing that isn’t always measurable but is no less real. Yet it’s not just continuity alone that matters, but continuity with compassion. How we show up is what transforms care from transactional to relational, making it a critical part of patient care. It holds us accountable, keeps our care human, and reminds us that presence can be profoundly diagnostic. In the end, it wasn’t the physical exam that mattered most. It was what those light, daily “punches” came to represent: the quiet power of showing up, not just as a medical student, but as a human being.

6. Before You Call Them Difficult

Arjan Bindra

JUDGED WINNER

Everyone on the team sighed when they saw her name on the list. “Room 712,” someone muttered. “Again.”

It was my first day on general medicine, and I didn’t yet know the shorthand. The unspoken labels that follow some patients from admission to admission.

We rounded on her last. She looked younger than I expected, maybe in her early fifties. Thin, with tired eyes and a guarded posture. Her chart said she was admitted for uncontrolled diabetes and recurrent cellulitis, but it was clear the medical issues were only part of her story.

“She’s noncompliant,” the intern said. “Refuses insulin. Always asks for pain meds early. Left AMA last time.”

I nodded like I understood. I was still learning the choreography of rounds. When to speak, when to observe, how to look like I belonged.

She barely acknowledged us. The attending explained her plan of care, but she interrupted. “I told y’all, I don’t want insulin,” she said, her voice flat but firm. “I know my body.”

The conversation was short and tense. We moved on in silence.

Later that afternoon, I offered to go back in to clarify her medications. I’m not sure why. Maybe I was curious. Maybe I just didn’t know any better.

She looked at me sideways when I walked in. “Another one of y’all.” I smiled and said, “Just the med student.”

Something about that seemed to soften her. Or maybe she was just too tired to argue.

I asked about her meds. She answered slowly. Then she kept talking. About how the hospital never got her prescriptions right. About how insulin made her feel shaky and sick. About her feet hurting all the time, and no one listening when she said it wasn’t just her blood sugar.

She didn’t sound angry. Just tired.

I asked where she would go when she was discharged. She shrugged. “Shelter, maybe. If they got space.” She said it like she was reciting the weather.

No one had asked her that on rounds.

Over the next few days, I kept stopping by. It wasn’t required. It just felt like the right thing to do. Sometimes we talked. Sometimes I just sat while she watched game shows with the sound too low.

She told me she lost her job during the pandemic. That she’d been rationing her insulin because she couldn’t afford both medication and food. That her brother died of an overdose last year, and she hadn’t really had anyone since.

She wasn’t difficult. She was surviving.

I started to notice how easily we labeled patients. Calling someone “noncompliant” made it easier to stop asking questions. Saying a patient was “difficult” let us off the hook when we felt helpless.

I wasn’t above it either. There were patients I’d silently judged, pulled away from, or written off because they didn’t follow the plan or made things uncomfortable.

But she stayed with me. The way she said “I know my body” wasn’t defiance. It was the voice of someone used to not being believed. And maybe she really did know her body better than we gave her credit for.

On her last day, as I walked in, she nodded slightly. “You’re alright,” she said. That was all. Just those two words.

No dramatic moment. No big goodbye. But I held onto them.

Internal medicine often lives in the gray. In chronic illness. In missed appointments. In patients who don’t do what we expect. In people who have been failed by systems long before we meet them.

We spend so much time learning about disease. Less about grace.

She reminded me that behind most “difficult” patients is a story we haven’t heard yet. That compassion isn’t about fixing everything. Sometimes it’s just about staying long enough to listen.

I didn’t change her outcome. I don’t even know if she filled her prescriptions. But I left that rotation a little less sure of my assumptions.

And a lot more sure of the kind of doctor I want to become.

Someone who asks before labeling. Someone who listens before deciding. Someone who remembers that grace, more often than anything else, is what medicine asks of us.

7. Smiling at the Moonlight

Corey Briska

He was born of an old yoke and older than most, but still, he had an empty look of a newborn. He had not seen the world, yet he saw it all. An innocent untouched, unscathed by the world. Some call it being lackadaisical, others call it apathy, but what I call it is unbridled love.

It was my third week. Strange for a stranger in a foreign land. I recognized not this barren plain. He knew I was timid, afraid not knowing what is up and what is down.

Nevertheless, he made merriment without hesitation. He knew of love.

I went to his room, adjusted him in bed, and asked if he needed anything. His smile was infectious and eyes bright as the moon that peeked into his room. At this time of night, there was a calmness and tranquility that brought out his best qualities. I wanted him to know that, but he wouldn't understand. He said to me, "Oh it is so cold in here." I told him,"It sure is."

Granted, the room was 85 degrees fahrenheit, but I didn't hold it against him. I left the room and stared at the empty hallway smiling. Leaving felt as if I left a friend I had known for years. Now, the moon to me never felt so cold and uninviting. It had a treacherous way of entering the building I thought to myself.

I showed up the next day to a somewhat vague, hazy dream. Lucid clouds and flashing lights. My mind was still languid and aching. I realized some patrons of the earth moved at a speed slower than the city, while others were quick to fly by. From fading thoughts to each step down the hallway, time had passed in no less than a couple of weeks. A friendly face entered the room while I was finishing up, I said to that bright eyed man,

"It is about that time." He told me, "Oh no, I hate doing this." I responded, "Don't we all. But are there worse things than being cleaned up?" He said,"Oh I don't know. Maybe castration."

I laughed. His wit was faster than anyone else's. After a smirk and making light of a grim situation, I saw that everything was in order. As I looked into his eyes, I saw a reflection of my older self. A man but of a different form. An altered corporeal shell. A spirit born from the soil on which I stepped. He was me.

When darkness rode into the night, I feared no one but myself. Alone and afraid. I avoided apathy at all costs. It protected me at my worst and destroyed me at my best. That was the price of being alive I thought to myself. One more fancy tickled me this sleepless night.

His mannerisms and gestures. His smile and contagious whimsy. I began to realize that I hadn't met a man quite like that. Maybe, I saw something greater in him than anyone else I have ever met. He was innocent. Pure and full of life. But throughout all my time, he didn't recognize me after all these weeks. He didnt recognize me. Every day, every waking day, no matter how many times. There was nothing. Nothing at all. He had it all figured out and lived in a world in which I knew nothing. Maybe, I was angry, or asking myself was this really happening?

Days later, it was time to talk to the people who had their understanding of their experience. Idle chat with the patrons of the earth. Time came, and I walked through the dusky hallway to his room. Same apparitions, same moon shining through the window. Now more than ever, it felt colder and less inviting. I pleaded for one more day. I said to him, "Hey man, it's about that time." He told me, "Oh c'mon, I hate doing this."

But I said nothing. I couldn't say anything more. I didn't have it in me. I wished him a goodnight and as soon as I was leaving the room, he said to me, "Hey buster, don't get in any trouble and make sure to get home safe. Ask me for a ride if you need one."

I smiled and said, "Will do."

His son had been fifty five years old. There was no need to mention that to him. His son had a job, was married, and had kids of his own. Nonetheless, I gave him that momentary solace. Because that's what he deserved. That's what he needed. An innocent man walks through life, and are we expected to give him his dignity or subject him to the cruel nature of reality? I chose love. I responded as if to give him the chance to feel the same way I did as a child. He smiled as I left the room and continued to smile as the next entered.

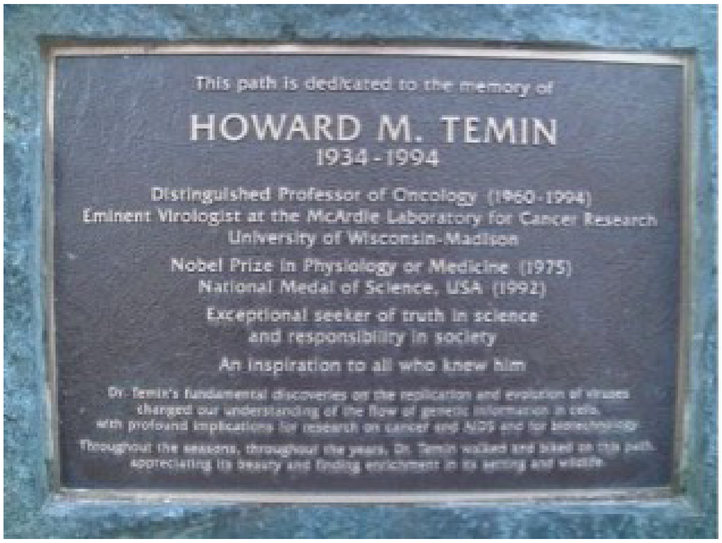
I didn't look back on that night. How could I have? Each time I say his name, I feel as if I knew someone worth something. Someone whom I'm indebted to. Seeing him in my mind didn't make me feel lost or afraid. I knew he was resilient wherever he was. Because at the end of the day, he was better than all of us. In these times, I listened not only to his words but his demeanor. I know I learned from the best. Do not listen to the cynics that cry out of adulthood consternation and gravitas. Live amongst the innocent. Relish in a joke. Be one with humanity. Love until the last heart beat. Thinking about him to this day, I come back to that place of love and sadness. Dying for him took only a second, but for me, it lasted forever. For the remaining week, I basked in the moonlight shining through the window knowing that I experienced life and death in the same breath.

8. Basic Science and the Unexpected Path Forward

Ian Gilson, MD, FACP

Recently while my wife and I were strolling along our beloved lakeshore path along Lake Mendota on the University of Wisconsin campus, we passed a marker that brought back memories. Dr. Howard Temin, who walked this path many times during his tenure as a cancer researcher at McArdle Cancer Research Lab, and who this path is dedicated to, gave a lecture that I attended as a University of Wisconsin undergraduate in a genetics course in 1969. He discussed his discovery of a novel enzyme he called RNA dependent DNA polymerase. He found this enzyme to be present in tumors of chickens, mice, and cats. It broke the cardinal rule of genetics, which is that DNA makes RNA, which makes protein. The concept of an enzyme which allows RNA to make DNA was revolutionary. He stated that this may be a key to the cause of human cancer. He won a Nobel prize for this work in 1975. As it turns out, he was wrong - the only human cancer ever linked to this enzyme is the rare T cell leukemia. However, this discovery turned out to be the most important concept I learned in college for the impact on my future medical career. In 1985 I saw my first patients with AIDS. Dr. Temin's enzyme, now called reverse transcriptase, was detected in lymph nodes of people with AIDS, and was produced by a virus initially called HTLV3, later renamed HIV. This virus infected T cells and devastated the immune system of those who carried it, leading to invariably fatal infections and secondary cancers. I was able to refer one of my first AIDS patients to the first clinical trial of a drug that blocked reverse transcriptase - AZT - and after the trial was shown to be successful, I was able to treat patients and extend their lives for a short period of time. Other reverse transcriptase inhibitors followed, with more efficacy and less toxicity, and then protease inhibitors and integrase inhibitors, which, in combination with reverse transcriptase inhibitors, led to highly successful combination therapy with restoration of the immune system and close to normal life expectancy.

This was where we were in the late 1990s. But we could see the immense suffering that AIDS was causing in Africa and other developing parts of the world where these drugs were not available. Then, in a meeting in Barcelona in 2002 with a nursing colleague who had done AIDS work in Uganda and was then on the Presidential AIDS Advisory Council and her Kenyan nursing colleagues, we advised the Africans to get ready for these drugs and that we were there to help, and within a year the PEPFAR program was created. In our teaching trips to Kenya in 2004 and 2007, we saw some of the first East Africans to receive antiretroviral drugs, and then witnessed the dramatic turnaround in their medical status Reverse transcriptase inhibitors are still the mainstay of therapy in the western world and their use in the PEPFAR program has saved over 26 million lives in Africa and other developing countries.



This path is dedicated to the memory of
HOWARD M. TEMIN
1934-1994
Distinguished Professor of Oncology (1960-1994)
Eminent Virologist at the McArdle Laboratory for Cancer Research
University of Wisconsin-Madison
Nobel Prize in Physiology or Medicine (1975)
National Medal of Science, USA (1992)
Exceptional seeker of truth in science
and responsibility in society
An inspiration to all who knew him
Dr. Temin's fundamental discoveries on the replication and evolution of viruses
changed our understanding of the flow of genetic information in cells,
with profound implications for research on cancer and AIDS and for biotechnology.
Throughout the seasons, throughout the years, Dr. Temin walked and biked on this path,
appreciating its beauty and finding enrichment in its setting and wildlife.

In 2008 I became a volunteer speaker at an annual Uganda HIV management conference, which was started by a collaboration between Dr. Frank Graziano, UW clinical immunologist and founder of the UW AIDS service (and former ACP chapter governor and Laureate awardee), and Dr. Peter Mugyenyi, whose work at the Uganda Joint Clinical Research Centre was fundamental to the start of the PEPFAR program. I now give annual talks to my African colleagues on clinical care of aging HIV patients. Now, as I wind down my medical career, I have had the great satisfaction of managing the common diseases of aging in my surviving patients with HIV, like diabetes, hypertension, and heart disease. I realize that the concept of growing old as an HIV survivor – not only here but globally - would have been inconceivable to me in 1985.

So speculation by a Nobel laureate about the implications of his groundbreaking scientific discovery that I learned about in college turned out to be wrong, but led to the most powerful healing I could do in my subsequent career, and the most impactful health intervention in the history of American foreign aid. Sometimes basic science takes us down a path whose destination cannot be imagined at the moment of discovery.

9. Where is my stethoscope?

Shabi Haider, MD

I had just finished rounds with my team one morning when I noticed my neck felt lighter. The familiar weight of my stethoscope was missing. My pockets remained overstuffed, but only with alcohol wipes and half-written progress notes. I checked my team room, nothing. Not at the bedside of the last patient we saw. Not clipped to the rolling computer, I borrowed it earlier from the nursing staff.

Where is my stethoscope?

I retraced my steps, trying not to get flustered. It was a gift from my wife upon graduating medical school, a midnight black stethoscope with an attached amplifier. It helped me hear all the murmurs, gallops, and even rubs! The last time its weight was on my neck was when I examined Mrs. Joyce, an elderly woman with decompensated heart failure, who kept asking when her daughter would be coming. She did not have a daughter, or at least not one who visited.

I paused outside of her room. I didn't see my stethoscope. Mrs. Joyce was fast asleep. "Finally on room air," I whispered to myself.

"Good," a nurse behind me at the station noted typing furiously, eyes fixed on the screen. A red call light blinked steadily, it was the same one from when we were rounding earlier.

"That room's call light has been on for a while," I said, offering a smile.

She did not look up. "I know. I'm finishing charting before I get pulled again. I've got six patients, and three of them have been sundowning."

I nodded, offering another smile. I did not judge her; the system has stretched us all thin.

"Where is my stethoscope?" I thought to myself.

I wandered down to the emergency department. Maybe I left it while assessing an unstable patient from last night. As I stepped through the automatic doors, I was immediately hit with fluorescent lights and chaos. A man was screaming in trauma bay 5, demanding the staff to give him his pain medications. Another patient was cursing bloody Mary at a nursing assistant as she repositioned the oxygen mask. Security was on their way.

"We're short again," one of the nurses exclaimed aloud at her station, her voice weary and tired and her head in her arms. "Two called out just now, and the new graduate just quit saying they could not handle being yelled at every shift."

I scanned the trauma bay.

Where is my stethoscope?

While taking the elevator back up, I passed the hallway where transport was trying to move an elderly patient into her room. Her gown slipped as she tried to stand and transfer.

"STOP! I can do it myself," she snapped. "I don't need help!"

"She refused nursing home again," someone whispered. "She said she is going home. Does not have one, though."

I kept walking, scanning the hallways, retracing my steps, now filled with an uneasy feeling of guilt.

I ended up in the intensive care unit. I helped triage an unstable patient last night. As I scanned around the patient room, I saw they were now intubated with multiple lines in their neck. The nurse seated outside of the patient's room recognized me from the day prior.

"This man is going to die. Why didn't you have a goals of care conversation with him before sending him here to die?"

I stood in silence. A wave of guilt, confusion, self-doubt, and frustration overcame me.

"Where is my stethoscope?" I remembered.

I made my way to the cardiology ward. I might have left it at the telemetry station while checking the rhythm strip for one of my admissions. At the telemetry station, an intensive conversation was unfolding between a resident and a nurse.

"I asked for Lasix at 8 a.m. The foley bag was empty the entire night," the nurse said sternly. "I put the order in; didn't you see it?" The resident replied, defensive.

"The MAR didn't update, and you didn't notify me. You can't expect us to guess your plan."

Silence.

The patient they were discussing was in room 5 with worsening symptoms from their newly diagnosed heart failure. Legs swollen, and skin stretched and shiny. The patient's son was next door arguing with the case manager about insurance coverage for a skilled nursing facility. This was the patient's second admission, and I had transferred them to cardiology the day prior. She was not eating at her skilled nursing facility, so her son was bringing her fast food.

"What do you mean we have to pay for her short stay at the skilled nursing facility? I thought

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that was covered from last admission?" The son questioned, clearly overwhelmed and frustrated.

"I'm sorry, her admission lasted less than three consecutive days, and the discharge day doesn't count." The case manager responded gently.

"I wasn't aware of that, and we can't afford the payments for her stay!" The son replied, taking a deep sigh and pleading with the case manager.

I eventually returned to my team room. The stethoscope was still missing, and my heart felt heavier than when I started.

That evening, after sign-out, I opened the resident lounge door. There, sitting on the counter next to an empty coffee cup and a wrapped piece of chocolate, was my stethoscope.

A sticky note was attached: "Found in the stairwell between 3rd and 4th floors. Figured someone would come looking. Here's a chocolate for your troubles :)."

I ran my fingers over the tubing. It had gone through its own journey, through this building, through the same walls that housed so many contrasting stories. I took a bite out of the chocolate, dark, not my favorite but still made me smile. For a moment, the heaviness lifted, replaced by something lighter, a reminder that even in the thick of chaos, having someone looking out for you can make all the difference.

I slung my stethoscope over my shoulders. It felt a little heavier now.

10. Stories We Carry

Maggie Holmes, MD

I held the cold hand of a boy who would never again feel his mother's touch. He was only nineteen, barely out of adolescence with unfulfilled dreams and a future erased by a single mistake. As a medicine resident, I have witnessed my share of pain, but nothing prepares you for moments like this - when a life is taken too soon, leaving only an echo of what could have been.

He was found by his mother. His body lay curled on the cold bathroom tiles - with his lips cyanotic and his breath shallow. The paramedics swiftly administered several rounds of naloxone en route without success and the patient arrived intubated and sedated. We fought with everything we had, but the damage was irreversible. He had suffered an anoxic brain injury and was declared brain dead.

I felt the weight of his absence, even though I was a stranger to him. His mother collapsed in my arms; her sobs were raw and pierced the sterile silence of the room. The question of why hung in the air. I didn't have an answer. Failure was not due to our medicine or our skills, but in something deeper—a failure of society and its law to protect.

Medicine is not just the physiology and pharmacology we studied in medical school. Medicine is messy and complicated, much like the flawed people and imperfect world they live in. My patient grew up in a neighborhood where danger was more abundant than hope itself. He did not choose to be exposed to drugs at an early age or to be failed by a system that turns its back on communities like his, but this was his reality.

We see the consequences of these systemic failures far too often. We patch up the wounded and send them back into the same world that hurt them. And unfortunately, we cannot heal a broken society - but we can demand change.

There are many roles we assume as a physician, but sometimes the hardest part is bearing witness to suffering. During moments like these, we stand with those who have lost everything, whether it's their child, their friend, their reason to live. While medicine is influenced by society, we can choose to define it by exhibiting compassion and carrying stories like these with us.

11. When Care Begins with a Song

Kaitlyn Jackson

“Patience is not the ability to wait, but the ability to keep a good attitude while waiting.” This is a lesson I have learned through various life experiences, particularly as I prepared for medical school while working as a nursing assistant at a veterans’ hospital.

Starting my overnight shift, I approached a door marked with a purple star, indicating that the patient had Alzheimer’s disease. I opened the door and introduced myself but was quickly met with a concerned look as “Amy” (name changed) shouted, “No! I don’t want you to touch me. Get me someone that looks like me!” Presumably, Amy did not want my care because I was a Black woman. Silence filled the room as I tried to figure out how to approach the situation. Maintaining my distance from Amy, to avoid agitating her further, I explained my role, what I intended to do, and how I aimed to provide the best care possible. After repeating myself, I realized my words were not getting through to her. I quickly scanned the room to find an activity that might calm her down and focused on a Hall & Oates CD. I told Amy we could check her vitals later and asked if we could listen to the CD together. Pressing play, “Sara Smile” started, and I shared with Amy how my grandma would play this song while cooking. I sang along and changed the lyrics to “Amy Smile.” The transformation in Amy’s demeanor was remarkable; her initial tension visibly diminished, and she became more open and receptive. After a few more renditions of the song, she agreed to allow me to take her vitals.

By taking the extra time to listen to “Sara Smile,” I built rapport with the patient and gained her trust. Despite Amy’s initial prejudgment of me, I knew my role as a provider was to give her the same care as all my other patients. In a vulnerable and agitated state, I was able to ease my patient’s anxiety while still fulfilling my duties. From this experience, I recognized my skills in problem-solving, finding common ground, and maintaining patience in challenging situations. The lesson of exercising patience and not giving up on patients is one I carry with me as a current medical student. I feel called to serve and advocate for underserved communities. No matter the challenges I may face in those communities, I will remain committed to helping my patients and not give up on them.

Reflecting on this experience, I recognize the importance of advocating for and serving underserved communities with unwavering dedication. The challenges faced by vulnerable patients, such as veterans and their family members, often go beyond medical conditions to encompass socio-economic and cultural barriers. My time as a nursing assistant has reinforced my commitment to approaching each patient with understanding, perseverance, and a genuine desire to address their unique needs. As I advance in my medical career, I am resolved to apply these lessons, ensuring that I remain steadfast in my mission to provide compassionate care and overcome the barriers that may impede patients from receiving the support they deserve. The ability to maintain a positive attitude while navigating the complexities of patient care, especially in challenging situations, will guide my approach as I strive to make a meaningful impact in the field of medicine.

12. Have you ever considered pediatrics?

Paige Johnson

As a third-year medical student who is woman and a mother no less, I have heard this question many times. The truth is, I *had* considered pediatrics as a specialty and soundly ruled it out during my pediatric rotation. During my six weeks alternating between inpatient and outpatient care, I had the opportunity to ask many residents and attendings why they chose to pursue pediatrics over internal medicine or family medicine.

The responses were strikingly similar:

"With kids, you know, they're innocent. They didn't cause their own health problems. It's easy to care for them."

"Their problems are more physiologic and less a product of lifestyle choices that you see in adult medicine."

"You're not battling a lifetime of health decisions like you would in internal medicine."

I listened and nodded while internally, my insides were roiling. *"That's healthism!"* I wanted to shout. Instead, I thanked them for sharing their thoughts while also noting how antithetical they were to my values.

I think my reaction is based on personal experience with working with adults who didn't have the resources, environment, or health literacy to make health a major priority. For years prior to medical school, I worked in the mental health field as a counselor and later as a registered nurse. Working in mental health meant encountering people who had a difficult time with interpersonal interactions, maintaining decorum in appointments, and even yelling at me during visits. During one of my many yearly trainings, one suggestion for encountering challenging individuals struck me: "instead of framing people's words and actions as behaviors, try thinking of them as symptoms."

This advice changed me in two ways: first, I was able to become more compassionate toward my patients. I naturally viewed behaviors as intrinsically linked with conscious choice, so shifting into a symptoms-based approach allowed me to have more empathy. Secondly, my own sense of peace increased. I wasn't harboring as much frustration toward patients anymore, because I started to understand that the challenging behaviors that I once viewed as choices could instead be attributed to symptoms of their diagnosis and environment. I want to emphasize here that I do not mean to divorce a person of their own agency in actions and words; holding empathy and using a symptoms-based framework still includes holding people accountable for their impact.

This new-to-me paradigm became even more helpful through medical school in managing my adult patients with chronic disease from what many consider poor choices: sedentary lifestyle, consuming ultra processed foods, and poor health appointment follow up, to name a few. These can all be considered symptoms of poverty, working multiple jobs with little time to devote to working out, lack of reliable transportation (or needing to share a car with other family members) getting in the way of making it to diabetic management appointments.

While this shift in framing challenging behaviors in patients helped me as a nurse and now as a medical student for my patients with chronic disease, it has been a far more difficult challenge to foster the same empathy for family members and patients who fall prey to health misinformation.

"You're going to have a hard time in the real world if you can't have patience for people just asking questions," said my mother's husband. We were sitting in the kitchen, and I had tears of frustration welling up. My exasperation was from arguing with him that banning red 40 food dye was not going to cure the United States of ADHD. This is just one in a series of similar scenes with my family members. I am first-generation medicine in a very large family, so there are a diversity of opinions and knowledge deficits when it comes to health.

Showing up to events in my family means that I often get a preview of what health claims are about to become national headlines. Sunscreen causing cancer is what preceded the food dye conversation at Easter. The resurgence of vaccines causing autism came up at Christmas. I heard about the carnivore diet at my wedding reception. When I hear patients repeat these ideas, I try to listen while internally weighing the pros and cons of attempting to engage them in a fruitless debate. My mother's husband was right about one thing: I needed to cultivate the same patience for them as I had for people with uncontrolled chronic illnesses.

They're afraid, I remind myself. They are doing the best they can with what they have. When I apply my symptoms-based approach to understanding them, it helps a little with fostering a sense of compassion and patience: they are getting their news from unreliable sources, they didn't get the same education I got about vaccines, they don't know how to pronounce oxybenzone. When someone with an online platform says, "doctors are lying to you, they get more money from keeping you sick," they listen because they are scared. This is a symptom of a divided population in which massive distrust in government and western medicine has been festering for decades.

I'm still working on the reflexive clench my whole body goes through when someone tells me they don't get vaccinated. My symptoms-based framework is still something that I need to practice. When I do use it, it helps with the burnout I feel. I apply my approach like a salve daily, because it helps me to keep showing up. And when we have a population overburdened with skin cancer from not wearing sunscreen, measles from being unvaccinated, and increased cardiovascular events from people following the carnivore diet, I will be there, compassion hopefully intact.

13. A Resident's Reflection on Advanced Heart Failure

Nathan Kuttickat, DO

As with many Internal Medicine residents, what initially attracted me to the field was the rewarding cycle of admitting, treating, and discharging a patient. While this appraisal has largely been reinforced by the last few years, more exposure to the outpatient, non-acute management of severe chronic diseases has complicated my understanding of medicine.

The patient population our hospital serves often appear to be captured by their chronic conditions. Our patients routinely return and are admitted for hypertension, type 1 diabetes or heart failure, despite the best efforts of both the patients and outside providers. Initially this seemed to be one of the down sides of hospital medicine, the effort of providing care remained the same but without the satisfaction of fixing the issue. It was hard to see any sense in these repeat admissions, as we reran previous treatments, offered resources, with the unstated understanding that they would be back soon. Therefore while the years of hospital medicine remained fulfilling, this was tempered by seeing some patients repeatedly for the same condition. These admissions were a nagging annoyance, seeming to point to deficiencies in our multidisciplinary team. My concerns persisted as I moved to rotate with consultant services or outpatient specialist clinics. Despite each rotation being a month in duration, we often saw a few repeat patients despite our interventions, suggesting this issue went beyond any one service.

My time with the Advanced Heart Failure Team(AHFT), helped redefine what success can mean when dealing with chronic disease. I was fortunate to rotate with this team in a split between inpatient and outpatient which sometimes allowed for following a patient from admission to follow up. These patients were almost always at end stage heart failure with frequent involvement of other organs, they either had been or were currently under evaluation for transplant. Often despite maximal medical treatment, slight changes in diet or even a viral illness would require admission. However, I found the AHFT's attitude to be instructive. Despite the frequency of repeat admissions, they were able to celebrate small successes without eliding the longterm poor prognosis for many of the patients. For many of these patients, they may not qualify for transplant, so the focus of care became maintaining quality of life and managing symptoms. Getting to see some of these patients after discharge was helpful in seeing the many ways they might end up readmitted. From overall fragility, lack of access, poor social support, to a myriad of other factors, there were often a number of reasons a patient might de-compensate. My experience with this team helped me accept that some times just alleviating some symptoms and helping a patient focus on the things that matter most to them was enough. With my return to the medical floors, I have tried to keep in mind all the hidden aspects of a patient that might lead them to return frequently. Even with patients noted to have "medical non-compliance", I have found it less distressing when they return; having redefined success as supporting them and maximizing quality of life. Overall my time with AHFT was personally helpful in addressing some of the unease with frequent bounce backs.

14. George. The dynamic nature of patient's wishes

Geoffrey Lamb, MD, FACP

George loved life. Professionally he was a general surgeon of the old school. He joined his father in private practice after completing residency and maintained the practice solo after his father retired. He married the love of his life and they had four kids. He worked hard but valued family and play. Friends and neighbors affectionately called him Doc. More than one person had a laceration repaired in the kitchen or an injury tended to in the yard. At the same time, he could be counted on to show up wherever a good time was to be had. Even in his later years he would be out there dancing with his adult children and their friends during the impromptu parties at the family lake house.

George was a firm believer in the value of medical care. As a true surgeon, "a chance to cut was a chance to cure". He himself had his bicuspid aortic valve replaced as soon as he was old enough to have it paid for by Medicare and had a hip replaced when it got in the way of having fun. However, he was also pragmatic as to the limits of medical care. His advanced directives were very clear. If things went downhill and the prognosis was poor, he did not want to spend the rest of his days on a ventilator or similar life sustaining measures.

Over the last few years his short- term memory began to fade. He knew his family and could carry on a conversation but could not tell you what he had for breakfast. He was able to care for his physically disabled wife but needed her guidance for daily tasks. Once able to ride his motorcycle to explore the back roads, he could no longer find his way when driving to previously familiar places.

The beginning of the end began with an apparent acute myocardial infarction at age 89. It was elected not to do an emergency catheterization. He was fine over the next few months but then began a slow decline with progressive congestive heart failure. He ultimately had an acute decompensation with severe shortness of breath and ended up in the ICU. His hypoxia and dyspnea were so severe that he required ongoing bipap to be transferred out of the ICU. He remained that way in the stepdown unit, bedridden and on bipap. He was only able to remove the mask for a few minutes to speak or eat a few bites. On a positive note, he could not really remember day to day that he had been in this state for weeks. He was able to communicate and maintained his sense of humor. Surrounded by family on a nearly daily basis, he quipped "had I known getting sick would bring me this much attention from my family, I would have gotten sick sooner".

Aware of his advanced directive and recognizing the impact of his illness on him and his family, we discussed with him whether he wanted to continue his intravenous lines and/or bipap. Taking his wife's hand, he smiled and responded "I'm happy - as long as I have this lady right here." He was quite content to continue in his current state and had no desire to discontinue his life supports.

An advanced directive is intended to provide for the patient's perspective in the event that the individual is unable to speak for themselves. Ideally it has been discussed with the patient's designated decision-makers so they can fairly represent the patient's wishes. As physicians, when a patient is admitted to the hospital with an existing advanced directive we often assume that this remains their ongoing perspective. Too often we don't take time to discuss those goals again after the patient is admitted or as the circumstances evolve. Perspectives change as the current reality changes. In a telling essay, Mark Williams describes a patient whose advanced directive thoughtfully requested comfort measures only, but then survives a near death experience. He quotes his patient stating, "when I was looking death in the face, I changed my mind".[1] Wong, et al, noted that nearly 50% of nursing home patients change their advanced directive within 2 years. They emphasize that advanced directives are dynamic and should be readdressed frequently, at least whenever there is a change in health status.[2]

In this case, the family and physicians felt the decision to continue his treatment was the right thing for him. He was transferred to a subacute nursing facility still bedridden and needing bipap. Then nature took its course. He passed away the day his 30-day Medicare subacute benefit expired. Knowing George, ever the pragmatic sort, this was probably not entirely a coincidence.

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1. Williams ME. The Patient Who Changed Her Mind - Medscape - Mar 09, 2021.
2. Wong, et al illustrate how advanced directives are dynamic and change throughout a nursing home stay. https://doi.org/10.1016/j.jamda.2024.105090

15. Six Weeks Away from Home

Jenna Loewus

In the summer of 2022, I had my first glimpse of a quarter-life crisis. I was nearing my time to embark on my medical school journey at the Medical College of Wisconsin, but my heart still felt heavy with the weight of unmet adventures and explorations. I had been grappling with the thought that I had not seen enough, met enough people, or understood the world beyond the confines of my familiar surroundings. This thought haunted me, as I wanted to experience those things to aid me in becoming an understanding and culturally competent person and future doctor. Fast forward ten months later and this is the exact goal that I had in my mind as I nervously boarded my flight to my temporary home: Kampala, Uganda.

Upon arrival, I was both nervous and excited. I had never traveled outside of the country alone before, and I was unsure of exactly what to expect when I landed. Uganda, a country in the heart of Africa on the coast of Lake Victoria, was a completely unfamiliar place to me. I was there to pursue one of my deepest passions, women's health research. On the plane, my thoughts raced with anxiety over not knowing the native languages, not knowing anybody there, and not knowing the culture. Despite these differences, I was committed to earning the trust of the community and ensuring that the research participants felt seen, heard, and valued. There was a rush of anticipation and a million thoughts running through my head as the plane wheels hit the runway, but before fear or hesitation could register, I was in a taxi on the way to my Airbnb. On the drive, I was completely in awe of the bustling streets, bright colors, heavy traffic, and hundreds of motorcycles (which I would later find out are termed 'boda bodas') weaving in between cars. My eyes were glowing with excitement, and my heart was racing with the anticipation of experiencing a world far removed from my Western education and culture.

Each day in Uganda was filled with life. The sounds of vibrant music blending with the hustle of people and traffic flooded through my windows in the morning. Car horns weren't just noise; they were a language – a form of communication to navigate unspoken rules of the road. Colorful markets along red dirt roads with smiling onlookers exclaiming "oli otya!" (or 'welcome' in Luganda) at one another. Amidst the chaos, I realized there was a mesmerizing kind of order among the people there.

My weekdays largely consisted of conducting interviews centered around early motherhood in Ugandan adolescent women. The stories of the participants provided the meaning behind the research I was doing. The mothers welcomed me with open arms and were willing to share not only their happy moments, but also their tales of hardship and resilience. The mothers were often faced with challenges, and the openness with which they spoke showed me their unwavering strength. I was always acutely aware that I was conducting research in a vulnerable population, and I knew that trust had to be earned. I aimed for each person I spoke with to feel like their voice mattered and that their stories were not being extracted but were being honored. I wanted them to feel the respect I had for their community, their culture, and their lived experiences as I recognized the privilege of being welcomed in such intimate spaces. I would also be remiss if I did not mention the clinic doctors, nurses, and staff at the Child and Family Foundation of Uganda. They allowed my colleagues and I to conduct research in their community on the grounds of their most prized possession, their clinic. I will forever cherish the deep connections I made with them and will strive to welcome people into my life the way they welcomed me.

Although I felt welcomed in Uganda, there were also stark challenges there. When I arrived, acknowledging my American life filled with white privilege, it was the first time I had ever been painfully aware of my skin color and the stares that were following me. I was the only white person in a community markedly different from my own. I felt both eager curiosity and a palpable sense of being an outsider in a land where I stood out. Language barriers and cultural differences were compounded by the visibility of my differences. It was initially jarring as I have never experienced anything like that before, but I realized that I needed to recognize it as a lens to gain insight that may have eluded me for the rest of my life. For the first time, I caught a glimpse of what it feels like to be visibly different, to be othered. It made me reflect on how many people of color in the United States navigate similar challenges daily, and highlighted both the strength that requires and the unjust systems that make that strength necessary. The research participants were often curious or surprised by my presence, but I found that a warm smile, a willingness to learn and celebrate local customs, and a respectful approach to their community helped slowly bridge the gap between us. The challenges of being a visible outsider in Uganda were both humbling and enlightening. And while I never got used to the staring, I did learn that sharing meals and laughing with the villagers went a long way—like when I tried (and failed) to dance a traditional Ugandan dance. It turns out cultural competence sometimes starts with a little humility, and a lot of natural rhythm I definitely don't have!

Many people have asked me to recount my favorite aspect of my time in Uganda. I grappled with this question for months. After a few years of reflection, I am very sure of my answer, as it is what I miss most about the country: the sense of community among the Ugandan people. It was unlike anything I have ever witnessed in the United States, or frankly unlike anything I ever knew existed. There is no need for childcare centers because their neighbor's child is their child; everybody helps to take care of the village children together. When food is scarce, nobody goes hungry because the neighbors give to each other without any hesitation. Shop owners will give food to community members

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in need with an unspoken trust that they will be paid back later. Individual struggles are shouldered by the village. This trust is so integral to daily life that it even affected my research: when our surveys asked about ownership of certain items to assess socioeconomic status, many participants answered “yes I own” to items like cars, microwaves, or radios. Upon further questioning, I realized these were sometimes items that they didn’t personally own but had access to through their neighbors. They would even laugh upon my questioning stating, “Why would I need one myself if my neighbor has it?” The strength of their connection to each other was even further astonishing given there are many different languages spoken there, even within their own villages, yet the understanding of each other never faltered. This way of life impacted me deeply and is one of the most profound aspects of my experience. In many ways, I consider Uganda to be the richest country I’ve ever been to—maybe not in material wealth, but in community, connection, shared resources, and, most importantly, in genuine care for one another.

I feel a sense of irony as I write this, because my experience in Uganda was genuinely indescribable. It was the way the air buzzed with the hum of life as we weaved through colorful stalls at the markets. It was the serene mosques which harbored some of the most peaceful environments I have ever experienced. It was the orange and gold hues as we rode in a Safari over the Nile River, bringing tears to my eyes as we witnessed a landscape filled with the horizon and vibrant wildlife. It was the warmth and kindness from the native Ugandan people that left me with a profound sense of belonging, despite only being there for a brief six weeks. It was the discomfort of standing out so visibly in a place far from home, and the humbling growth that came with striving to understand what life looks like through a different lens. Out of all the things I have accomplished in my life, I am most proud of my time in Uganda which has since become a moment preserved in time. The stories shared, the lives touched, and the resilience witnessed has left a mark on my soul. As I boarded my flight back home, I left with more than just a research journal submission. I left with an experience that not only challenged my strength as a human being but revealed to me what it means to be truly rich, a truth I will carry with me through life far beyond medicine.

16. Pastry and Patients

Lauren Marlatt

I sat with my nose pressed up against the oven door. I have been attempting to perfect my great-grandmother's pie crust recipe for years and recently declared my edits finalized. Every time I changed the butter-to-shortening ratio, the texture, taste, and bake time threw me for a loop. These seemingly simple ingredients produced varying amounts of steam as the water contained in the butter vaporized thus creating lift and the elusive flake. Steam is such a simple substance, but it gives life and functionality to an infinite number of everyday processes.

I take another quick peek in the oven at the slowly rising pie crust and grin when the heat washes over my face. The same steam that escaped from the pie dough as it baked transported me back to childhood and into my grandmother's kitchen. Watching ingredients become a single dish has captivated me since I was a little girl being taught the importance of ratios from my grandma Helen. Stick to the all-important flour-to-fat-to-sugar proportions and you will get a perfect product every time. As the dough comes together, the swirls of butter appear dynamic; it is impossible to follow each ripple through to the end. The dough cools down in the freezer before hitting the 400-degree heat of the oven. This crucial step allows the butter to heat up slower, allowing more steam to push the layers of crust apart. I have come to appreciate the study of simple concepts and watching the complexity grow as my knowledge grows.

Nurturing this craft has given me the confidence to persevere and experiment with new strategies. There is still value in the crust that does not rise properly because the oven was not hot enough or spills into a mess because of warm dough. The lesson learned and the thoughtful adjustments to the next attempt can give me the same satisfaction as the "perfect" pie. For the time being, I have finished tinkering with my great-grandmother's original recipe, and it looks nothing like the start. I have poured years of trial-and-error into a four-ingredient pie crust. There is always room for improvement; however, sometimes it is also appropriate to acknowledge how far you have come and enjoy watching the crust you have created rise in the oven.

Just as mastering pie crust demanded patience, a scientific mindset, and appreciation for incremental progress, so too does the path to becoming a physician. In medical school, I face steep learning curves, complex systems, and countless "recipes" for care that must be carefully studied, practiced, and refined. Like chilling the dough before baking, sometimes the best results come not from rushing but from preparing with intention. My time in the kitchen has taught me to respect both the science and art of creation—whether it's pastry or patient care. I now recognize that imperfection is not failure but rather a step toward mastery. And like watching a crust slowly rise through the oven window, I am already enjoying the quiet satisfaction of watching knowledge, care, and experience come together in the service of others.

17. Atonement

Alex Nelson

“Get up. We’re crashing a section.” the OB Chief spat, blankly. She peered through the dim storage closet at the disheveled mess of a nascent medical student, returning her gaze from his catatonic sprawl across a 40-year-old futon a foot too short for him. It was 3:46 in the morning.

A membrane of drool separated my right cheek from the crisply laminated cover of Williams Obstetrics, 26th Edition. The frigid, alkaline air smacked that same cheek as it rose to meet the indifferent gaze of the figure before me, laced with the sneering sting of failure that haunts my subconscious, my dreams, riddled with the pejoratives of *Williams et al.*, “couldn’t tough-it, huh?”

I choose to forget my last all-nighter just as I now strain to remember a week’s worth.

In a fugue, re-lacing my parachuting scrub bottoms as I center my crooked glasses on the figure, now illuminated under fluorescent hum, rounding the corner onto the unit. She was nearly as tall as I, yet she towered over me, now, scampering after her like some callow dog.

My clogs plunge through the sky-blue tissue of the OR booties. Brisky recalibrating as I stuff my long, brown locks into the bonnet of similar structural integrity, I list forward and plow my torso into the neatly stacked shelves of PPE – my face, fortuitously, breaking my fall. “Jesus Christ”, the Chief muttered, mashing the foot pedal of the scrub basin behind me. “*If* you do anything in my OR, it should be to fall backward.”

The doors to the two-stall, pit-stop of an operating theater scissored closed behind me. *Inferno*. I belly-up to the basin in-toe with the Chief, who now, arms cocked like a praying mantis, body checks the inner release door. That unholy shudder cracked a glimpse into the roaring opera awaiting within. Teeming, electric. My dysmetria – the smog of sleep still shrouding my dexterity as I picked at shreds of hangnails decorating deeply fissured fingertips – stood in gleeful opposition with the ethos of the person whose back faced me, separated by the pain of hatched glass.

“8s, please.”

“Do I look like a vending machine?”

The ORs upstairs were methodically paced. Time, an ally of electives, spoiled me. The tiled cathedrals kowtowed to their orchestral ranks with frank grace, summoning equipment, PPE, and bodies with rhythmic incantations, of which my tongue was fluent. Two floors deeper, currents of heat and Hedonic intonations reverberated against the hollow tympanies and castrating gaze of the surly woman before me. She was the sentinel of the equipment table, pathologically organized, to spite pandemonium.

Gloves snapped, heels twirled, and the sapphire curtains called the stage to a hush – *time-out*. The Chief and I assume formation – flanking the striated, pulsating, purpuric mound taunting us. Without meeting my gaze, from fumes of black Sharpie sculpted a Pfannenstielian maquette, crude and greasy, pierced by ashen linea – *“X” marks the spot.*

Palms clasped at my navel, a Pavlovian response, cleaved with a spiteful blow. The Attending, of unassuming stature but dwarfing both the Chief and I, mounted her pulpit to my right. The Chief, whose apathy shunned me to submission, the Attending’s fiery gaze locked mine, briefly, but steady – conveying, not warmth, not ease, but unfaltering contempt.

“This your first time?”

“Yeah..”

“Fucking Christ, here.”

Armed with electrocautery and suction, transfixed, I steadied my bead just as the mound opened its mouth to reveal its tart, earthen hues. Pink, pale, cream, crimson spiraled down as the mouth roared a divine comedy. Liberated from the Cocytus crypt, the pale, limp lamb of God.

Chorio, abruptio, the ivory noose throbbed, glistening in heavenly light, ensnaring its ethos, its sole prerogative, with an indifferent vice. *Now, I am the arbiter of this fickle life.*

“0 APGAR.”

Need I say more?

“0 APGAR.”

The shepherds of purgatory burst through the door.

My id, my mortal degeneracy, blooms from the smell of searing flesh and squelching of viscera courses through its new vessels, ruby rivers channeled to troughs clot and connective tissue. The Promethean Attending, bestowing such seductive power, chastised my lustful zaps with each strike of my quivering hand.

Trepidation bleeding to tenacity, my psyche wavered between sensitization and habituation. Amid flagellating blows, my heels soon began to bear weight, more than they ever had in 23 years, as my weary eyes fell to those of the mound. Tall enough to peer over the spectral shroud – suspended between our lives – were its deep, mahogany eyes. The soothsaying serpentine slithering from her dorsum whispers psalms of senesce to the mound, but not to her complicit gaze as it now met mine. *Sclera silhouetting placid fear, anguished innocence, hopeful hopelessness.*

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Unbroken by the jerks of her thorax as the mound's mouth agape, barring-down on stainless-steel sacraments – prayers of Pitocin and vows of Vycril – seared my forearms in strain. The currents of crimson sneer with the same cruel jest as the words of Williams et al. as they scurry past my Bovie. Tagged lap, lap, lap, lap, lap, lap! I damned the mouth – *Angel of Light*, its six eyes weeping tears of bloody foam – split in three by our liturgy. *Hemostasis, blessed be thy name.*

Waves of parishioners, bathed in auspicious light, march past my sinful silhouette, spat from the jaws of night, to harken rebirth from within the chapel, a dire rite. Pangs of color and form painted my retina a mosaic of memory – the scaly OR locker, the saddle of my sedan, the Bradley Clock, the sentinel of the cityscape, the groan of the steps of a South Side bungalow.

A corpse in my childhood bed – baptized by the woes of a man I no longer knew, or perhaps, never truly did – I couldn't have been farther from home. I plead, so desperately, to persecute. *You, you, you are to blame!* How foolish was I? How foolish was I, in my privileged daze, to tread in vain across the blossoms of inequity, their velamentous roots impregnating concrete and rebar, frozen in the catacombs of the city I was no longer welcome, and, perhaps, one I never truly had been.

I sink my teeth into my pillow and atone – I was 13 again, weak and weeping – the golden rays of disdain shimmer over my writhing frame. Lucidity breaks against the necrotic cliff of a pathetic excuse for sleep.

~

In the black of night, I clench the throat of divinity and bellow a thousand tragedies.

Why this torment? Why this retched ache? Why curse the weary soul, yet fail to break?

Swaddled in heavenly light, they gasp with labored breaths the ichor of hellfire and spite; a roaring opera of ruin raises requiem that I can no longer fight.

The blood of angels' courses currents between our grasp, rivers of virtue, shame, honor, hate – baptize us across the sterling alters of Lent.

Cascades of crimson light now ignite the sky with the hues of rebirth and repent.

God is dead, and all that is holy shall know contempt.

18. The Discharge Plan*

Abishta Prabhu, MD

In medicine, we are taught to diagnose, treat, and discharge, but sometimes, we miss the quiet truths patients carry beneath the surface. Some patients linger in my memory, not because of the severity of their illness but because of things that they may not have been able to say. Some of the most meaningful lessons I have learned during residency did not come from practice questions or morning rounds but from the stillness between clinical decisions. Those moments when a patient's story reveals something far more complex than the diagnosis on the chart. One such moment came earlier this year with a man whose acute medical concerns were resolved quickly but whose silent struggle began the moment we tried to send him home.

Mr. H was admitted to my inpatient medicine team with community-acquired pneumonia. He was in his mid-50s, polite, and strikingly put together. Each morning, he greeted me with a firm voice and made jokes with the nurses. His button-down shirt was neatly pressed, and he kept a small notepad by his bed where he jotted down his questions. On paper, he was an ideal patient: cooperative, clinically improving, and without complications.

By hospital day three, his oxygen needs had resolved, he was asymptomatic, and his labs showed no further acute concerns. Medically, he was ready for discharge. But every time I mentioned it, he'd hesitate -just slightly. He'd ask if the antibiotics might work better if he stayed another day. He'd say he didn't feel quite "100%" yet. At first, I chalked it up to understandable caution. However, then came the requests for extra meal trays. The missed rides home. The reluctance to schedule a follow-up.

There was something unspoken hanging between us, something that didn't quite fit with his calm demeanor and outward organization. On the morning of day five, I sat down next to his bed rather than standing over it, and asked gently, "Is there something you're not telling us? Are you unsure about going home?"

He stared at the wall for a few seconds before turning to me. "It's not that I don't want to leave," he said quietly. "It's just… I don't really have anywhere to go."

The words hit like a quiet storm.

He explained that he had been living in his car for the better part of a year. The pandemic had taken his job. Then came the eviction. He had no family nearby, no savings, and no one to turn to. Everything he owned was packed into a few plastic bins in the backseat of his car. His appearance, so clean and composed, was something he clung to, not out of vanity but survival. "People look at you differently when you look like you're homeless," he said. "So I don't."

He hadn't mentioned any of this earlier, afraid it would change the way we treated him. He said the hospital was the first place he'd slept in a real bed and eaten three full meals in months. It was so coincidental that although he came to the hospital sick, this was probably the most "stable" he had felt in a long time.

Throughout medical school and residency, we received frequent lectures on the social determinants of health, but at that moment, it was no longer theoretical. Here was a man who had survived pneumonia but was still vulnerable to the cold, the stress, the hunger that likely contributed to his illness in the first place. He mentioned days of skipping meals, relying on convenience store snacks, and occasionally rationing soup cans in his trunk. Food insecurity was not his main complaint, but it was woven into every part of his health.

Together with case management and social work teams, we found him temporary placement in a shelter with medical respite services and helped connect him to a community food pantry. It was not a perfect solution, but it was something.

I think of Mr. H often. Treating his illness seemed as though it was the easy part, and after discharge, he still had hardship to face. As physicians, we are trained to recognize disease, but we must also learn to recognize the silent battles people fight outside of the hospital. We have to ask uncomfortable questions. Not just "Are you safe at home?" but "Do you have a home?" Not just "How's your appetite?" but "Do you have access to food when you leave here?" It amazed me how easily someone can slip through the cracks while appearing "fine." He taught me that people don't always present their full truth at the door. That dignity can mask need. And that healing does not simply end with the resolution of an infection.

** For my submission I changed the patient's name, hospital course, diagnosis, and specific parts of the story including how long they were in the hospital, date they were in the hospital, family situation, gender of the patient, and some of the conversations are exaggerated. The patient would not be able to be identified based on my story.*

19. Uncertain Bravery in the Face of Certain Death

Devon Riegel

"How much time do I have left?" The man who was our patient was accompanied by his wife, and their shoulders were ever so slightly inclined toward each other as they braced for a terrible conversation. I was an M1 student observing my mentor's Neuro-Oncology clinic for the first time, willing myself to convey empathy in my silent position from the corner of the room. My mentor nodded to the patient and held her hands in front of her, palms slightly cupped and facing upward: "I don't have a crystal ball, and I don't have one hundred of you, so I can't give you an exact number." The patient mirrored her nodding, thin streams of tears trickling down his cheeks. My mentor continued, "What I can say is based on my experience with hundreds of patients, and with your disease, it's likely on the scale of long months to years." My mentor let the silence hang as the patient considered his life before him, a corridor of uncertain and unknowable length with a darkened doorway looming at its end. His wife reached for another tissue.

This man was one of many patients with glioblastoma (GBM) who I met through the course of medical school. Other faces join him in my lineup of memorable patients: the man whose GBM had metastasized to his cervical spine, causing a Brown-Sequard syndrome that prevented him from playing guitar; the woman who was nearing five years since her diagnosis and invited my mentor to her celebration party; and the woman with a new suspected progression who seemed unphased, either from lack of understanding or lack of concern, it was unclear. I met that first man a few more times in clinic as he progressed through the cycles of temozolomide. His face, no longer wracked with fear and pain, was now a flattened sheet, and my mentor counseled him about potential medications to treat depression. He shook his head, "I'm not depressed," and agreed to plod along to the next month of treatment.

People from all backgrounds wound up in Neuro-Oncology clinic with GBMs, and yet one through line united them. While I was frequently struck by the devastation of the disease, I was similarly struck by the optimism and bravery with which nearly every patient faced their demise. Most patients, to my surprise, arrived at clinic with sobered yet positive attitudes, reporting that their last cycle of temozolomide went without a hitch and that they felt up to increasing their dose for next month. The man with Brown-Sequard syndrome would raise his weakened left hand and say, "I'll keep trying." The patients with recurrence would look at their scans and simply ask, "What do we do next?" This group of seemingly random people, not grounded on any risk factors or genetic predispositions, stood face to face with death and said, "press on." What made these patients so special? How did they wield such uncommon bravery?

I have seen people balk in terror at something much less grave than a brain tumor. I would be inclined to believe that maybe the frontal lobe predominance of GBM tumors was impacting their ability to respond as expected to their situation. However, one patient I have seen outside of the Neuro-Oncology clinic reminds me that bravery in the face of death can come in many forms. That patient is my Korean grandmother, my Halmeoni. I visit home to see her and my mom on a quarterly basis, and those reunions are punctuated by lunches and dinners spent debriefing on the wellbeing of our family and each other. Whenever our conversation drifts toward the future, like how I hope Halmeoni will attend my medical school graduation in person, she always responds the same way. She leans back in her chair, eyebrows raised with open frankness and says, "You never know, I could die tomorrow." I wave away the foretelling of her own death and remind her how healthy she is, to which she just shrugs: "Anything can happen. The most important thing is health."

Perhaps Halmeoni's frequent preoccupation with her unpredictable death is cultural, some form of Korean pragmatism that prepares for the unknown moment of the end. Maybe it stems from her early experience of the Korean War, when she – at twelve years old – would walk alone through rows of armed soldiers to barter for rice for her entire family. Or, and more likely, it's just her nature. Halmeoni has been notoriously hard to care for as a result of her mental toughness. When she was hospitalized after an emergency cholecystectomy, the surgeon telling us it was the worst and most gangrenous she had ever seen in her career, Halmeoni insisted she wasn't suffering. Every morning, a med student much like me would wake her at 5 AM to ask how she would rate her pain, to which she would say, "No pain." While Halmeoni always says that her health is most important, perhaps what is actually most important to her is dignity and bravery. More important than keeping herself alive for another day is to maintain her sense of personal strength, even in the face of a gallbladder that was trying to kill her.

During one visit home in the summer, my mom asked if I had noticed the hydrangeas in the front yard. I had, and every year they seemed to grow bigger and more bountifully than the one before. My mom gave me a surreptitious, knowing smile. "Well," she said, "Halmeoni thought that Harabeoji's ashes were just sitting around, and she realized they would make great fertilizer." The cremated remains of my grandfather, Harabeoji, had been sitting on a shelf for at least two years after his battle with pancreatic cancer ended as expected. Halmeoni had figured, ever the practical woman, why let his ashes go to waste? My mom and I had a good chuckle, thinking of my historically cantankerous grandfather feeding years' worth of big fluffy flowers. I thought too about Halmeoni's perception of death. At the end of the day, we all return to the earth, and what matters is not how it happens, but how we deal with it during our lifetime. Barring accidents

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and unforeseen tragedies, it falls to no one but the one who is dying to decide how they want to go. Harabeoji's death was slow and at times agonizing, but he remained stoic as Halmeoni took care of him. He took his final breath while in a comatose state at home, and we held vigil around his physical form, which is now immortalized anew in the form of pink petals.

So, are the GBM patients different? Is their bravery an anomaly given their prognosis? I think not. I think the truth is that all patients are capable of remarkable courage. I think it is our medical system that fears death more than our patients. When I tell people in medicine that I am applying to Neurology, I'm sometimes met with discouragement. Why would I want to go into a field where I may never cure my patients, when I have to watch them slowly become debilitated from their disease? Why would I want to care for patients with deadly brain tumors? Isn't that too sad? I find myself wondering why some doctors are so perturbed by incurable disease. As a Neuro-Oncologist, I would not save lives through angioplasties or cholecystectomies. Instead, I would guide patients through their chosen responses to their diseases with respect and grace. Isn't that a worthy cause?

I believe that all patients have a greater capacity for bravery than our system permits. Modern medicine has fought indiscriminately to cure all known disease. In that effort, we've forgotten the fundamentals of human life. We cannot cure death; it comes for us all. Rather than focus our attention on every possible remedy for disease – however unlikely to succeed – what if medicine refocused on the quality of life remaining for the humans we serve? Sometimes the best medicine can offer is comfort at end of life. It should not be a failure for medicine when a patient with GBM decides to enroll in hospice and face their death with personal dignity and strength. Let bravery be the cure for fear, both for our patients and for ourselves.

That man whose tears I witnessed years ago has now passed away, but I will never forget him. I will always feel grateful that he shared his humanness with me in a moment of deep vulnerability. I will always remember his bravery, like so many other GBM patients, as they faced their death with dignity and strength. I hope his family found peace with his passing and remember him not in death and disease, but in life. I hope that somewhere in the world, his body and memory found life in perennial blooms.

20. Waiting

Samantha Shapiro, MD

There is a quiet, frenetic sense of both anxiety and boredom that permeates the family waiting area down the hall from the ICU. People sit alone or spaced apart in groups of two or three, in "comfortable" chairs, some of which rock, most of which sit erect with cushions that betray the sound of every little movement. There are a few small tables scattered about, all empty apart from some months-old magazines and the stained imprints of coffee cups long past. A TV that is mounted in the corner plays muted reruns of HGTV. Everyone is silent, communicating in hushed whispers until a phone chimes or a medical provider comes in to deliver news or ask a family to join them in a separate, more private location. Every so often, someone laughs or sighs at something on the TV or on their phone, but the sound quickly dissipates. If you were to look up "thousand-yard stare" in the dictionary, this is the scene that you would find: a hodgepodge mural of people who are together, yet seem entirely alone in their own minds.

In one corner of the room, there is an older couple, both in fleece jackets and sweatpants. The woman sleeps with her head on the shoulder of the man next to her. The man frowns and looks at his phone, or at the TV, or at one of the magazines that are strewn around the sterile tables. He doesn't talk; he doesn't smile. Across from this couple, closer to the middle of the waiting area, is a woman sitting alone in a chair. She is dressed as if she just got off work at some sort of executive position. She scrolls on her phone, reading the news and playing games and constantly, constantly looking at the door. At one point, she gets up and walks to a chair that is closer to the door. There is a blue "please choose another seat" sign on the chair, but she sighs, moves the sign, and sits down anyways. She resumes scrolling her phone and staring at the door.

It is a strange thing, to open the door and walk into this setting. To see all eyes immediately turn to you, and to feel the stress and the anxiety and the smallest amount of hope radiate off the families and immediately wash over you. When you find the family you are looking for, the conversation is short and without major updates or changes to the plan. Both you and your patient's family are disappointed there isn't more to discuss. Yet despite the shared disappointment, there is something inexplicably human about participating in a scene like this; an almost ritualistic process of waiting and distracting and thinking and trying to pass the time. For some of the families, when the ritual ends, there is an exhalation of relief and sometimes tears – an exiting of the nerves that have been buried just under the surface for hours and days on end. Of course, in the ICU, not everything ends in relief; sometimes, the tears that come belie a shock and numb horror. Sometimes, lives are forever changed due to the unexpected and unthinkable. But not today. Today, there are no major updates, and the waiting families seem to welcome the intermittent laughs and smiles that represent normality and a life outside of this waiting area.

PEOPLE'S CHOICE WINNER

21. "She Was Watching Over Me"

Mukul Sharda

I met him on a quiet morning at the VA, where time seemed to move differently – slower, heavier, laced with memory.

He was a Vietnam veteran, mid-sixties, wiry frame, weathered face. The kind of patient who walks in carrying more history than paperwork could ever capture. His labs were routine. His story wasn't.

He started talking while I was typing. Not just about symptoms or meds, but about the war – his war. "Saw some messed-up things," he said. "Stuff I don't talk about with my kids." He paused. "Stuff I don't even talk about in church."

I stopped typing.

He told me about the firefights in the dense jungle. About watching friends die. About the sound of helicopters, which still made him flinch.

"I came back, and I wasn't right," he said. "Didn't know how to come home." He got into drugs – selling and using. Spent years in prison. "That's where I had time to think. That's where I remembered my mama."

She had passed when he was eleven, but she never really left. "She used to pray over me every night," he said. "Even now, when I close my eyes, I can hear her. Telling me I ain't too far gone."

He held onto that voice – through addiction, through prison, through decades of trying to rebuild.

Now he owns a business. Three houses. He's got tenants and grandkids. He's clean. He's present. He goes to church every Sunday. "People think I should be dead or in jail still," he said. "But she was watching over me. I know she was. God too."

There was no bitterness in his voice – only grace. He wasn't asking for pity or admiration. Just telling the truth of his life, raw and redemptive.

He mentioned how he attends chapel at the VA every week, even though his prostate issues mean he often has to slip out mid-service and come back. "I just go and come back," he said, smiling, like it wasn't even a question. "I want to be there. Ain't nothing gonna keep me from that."

And support groups – he goes to those too. "Because there's always someone worse off. And because hearing it out loud helps me hold it in better."

That day, I didn't fix anything. I didn't adjust meds or make a referral. I just listened. And in that exam room, the sacred and the clinical blurred.

We talk a lot about treatment plans. About metrics. About outcomes.

But sometimes healing looks like a man with scars telling his story and still believing in something bigger. Still believing his mother never left his side. Still believing he's worth saving.

I walked into that visit thinking I was going to talk about lab results and medication side effects. I walked out with something far more lasting – a glimpse into what survival looks like after everything falls apart. A reminder that recovery doesn't always follow a neat curve. That progress can be invisible to most eyes but unmistakable when you listen closely.

His story reminded me that the human spirit, when held together by faith, memory, and purpose, can outlive war, addiction, prison, and pain. That a body may carry illness, but a soul can still choose grace.

He reminded me what it means to be resilient – not in the sense of bouncing back, but in enduring, evolving, holding on. Even when your bladder won't let you sit through a chapel service without interruption, you still show up. You still return. That, to me, is the kind of faith that sustains – not loud, not flashy, but quietly relentless.

I think about him often, not because I diagnosed or treated anything that day, but because I bore witness to his story. And that felt like medicine too.

There's a line we walk in this work. Between the scientific and the spiritual. Between checking boxes and showing up fully human. He reminded me which side I want to live on.

And on days when I'm tired or jaded, or wondering whether anything I do truly matters, I remember him. His voice. His mother's voice. The quiet dignity of someone who could have been forgotten but refused to forget himself.

22. From Cards to Compassion

Adileen Sii

The shadow of the withered pink flowers lingered over the ghostly shape of a worn-out deck of cards on the cold windowsill. A rematch had been promised after Easter. A mere four weeks earlier, my anxious first hospice visit was with the "cranky and argumentative patient." Nervously shaking her petite hands with my gloved, sweaty palms, she immediately stated we were to play "King's Corner." Afraid to admit I had never played, after a few rounds, we carried on like old friends, bonding over her bird-watching hobbies and our feisty competitive natures. Visits beginning with "I've been waiting all day to play cards with you" ended with her asking if I would return next week. Indeed, she was snarky to caregivers whenever dinner time interrupted. However, "cranky and argumentative" was misunderstood for her loneliness and longing for companionship.

In that quiet space, I found myself learning about the complexities of human connection, especially when faced with the inevitable end. Reflecting upon my patient's experience, I contemplate how often my grandma had been labeled as difficult because others did not understand her. She depended on my ten-year-old self to accurately relay her story. I remember feeling stressed and pressured because I did not have a strong command of either of my languages. It was through these moments of miscommunication and empathy that I realized how often we, as healthcare providers, fail to see the vulnerability in our patients' behavior.

"Will you sit with me?" "How long will you stay?" Holding her hand to reassure her of my presence, her body relaxed into a peaceful slumber. I then understood the "beauty of passing peacefully." As the spunky, free-spirited "card sharp" rigidly laid disoriented and incoherently mumbling, her hearty smile and twinkling eyes hid behind her heavily-closed eyelids, clear indicators of the physical burden her body endured since our last visit. The dreaded moment had come. Prior to volunteering in hospice, I thought death was something to be feared and avoided at all costs. But as I sat with her in her final moments, something shifted in me. I understood that death was not something to avoid, but rather, something to meet with compassion, dignity, and presence. It was not the end of the story, but a chapter that deserves care and respect.

Throughout our four short weeks, her snarky comments and life reflections rarely failed to hide her fatal cancer diagnosis. I had no idea how to talk of it, let alone grieve over a loved one.

Suddenly, death ceased to be an abstract idea. I had to face it straight-on. I had to face the immanence of her death, of her permanent passing. My time with her matters because it broadens my understanding of what medicine encompasses—not just saving lives, but also helping patients with the end of life, offering them a safe and compassionate space to embrace their journey.

My relationship with the patient had flourished, poignantly illustrating genuine patient-centered care. She showed me the true meaning of resilience and the kind of physician I want to embody—one who meets patients where they are, with empathy, compassion, and the readiness to sit with them in their most vulnerable moments. This experience has not only deepened my understanding of medicine but has also helped shape the physician I strive to become—one who embraces the delicate balance between life and death with grace and respect.

23. Nothing More To Do*

Rikin Soni

It was my third week of preceptorship as an M1. Or as I like to call it, "playing doctor" for four hours a day to learn lifelong clinical skills. My preceptor, Dr. A, a kind-hearted man, and a brilliant general surgeon asked me to go see a ventral hernia consult in one of the exam rooms. I nodded in affirmation.

That had been the routine the past couple of weeks. I would come to the Specialty Clinics around 12:30 p.m., after walking through a maze of hallways and fake plants. After a bit of small talk with Dr. A and M, the APNP, I would do some chart review, grab HPI from my assigned patient, perhaps do a quick physical if I felt brave enough. With this information in my handy notebook, I would stroll back to the office to present and get feedback from Dr. A and M.

After reviewing our patient's chart, I walked down to exam room with purpose, trying to remember the order of questions I needed to ask. I knocked on the door and heard a quiet "come in." As I stepped in, I realized she was masked. I covered my mouth and politely asked if she would prefer that I wear a mask. She nodded politely in a midwestern way. I grabbed a mask from the front desk and headed in.

I started with, "So, what brings you in today?" And the patient interview began. Over the next fifteen minutes, I learned many things. I learned about her mischievous cat, her continuous unemployment preceding COVID, the worsening of her hernia, and the autoimmune condition that had defined her identity for the past thirty years. She explained how she had planned to fix the hernia in 2020, but COVID hit. She elaborated on the paralyzing fear she experienced stepping outside the comfort and safety of her home with her autoimmune condition. At one point, she got teary-eyed, expressing how much courage it had taken her to come to the hospital today. I recognized her courage and thanked her for being vulnerable enough to share her story with me.

To those unfamiliar with hernias, you fix them when they enlarge, cause pain, or pose a risk of complications like strangulation. Otherwise, they can be left alone. Over the past five years, her hernia had worsened to the point that it affected her daily life. Her pre-COVID pain was 2–3 out of 10 (when most patients would consider surgery). Now, it had progressed to 7–8, sometimes a 9.

I outlined the surgical options, mesh considerations, and how her autoimmune condition might affect her recovery. I assured her of Dr. A's expertise, praising his surgical skills and bedside manner, which I admired greatly. I answered her questions and exited the room.

Walking the ten steps back to Dr. A's office, I felt a deep sense of accomplishment. These were the moments that drew me to medicine. I presented the case, and we discussed her old CT scan from her first consult pre-COVID. Given the latest information I shared today, Dr. A recommended an updated CT for safety—a reasonable request I readily endorsed, not yet understanding what this meant for our patient.

Prior to entering the room, I asked Dr. A – with as much courage a first-year student has when addressing an attending - if he would not mind wearing a mask. He smiled, picking up his mask, and we stepped inside.

Dr. A introduced himself and took our patient's history. She stated she was ready for surgery—today was finally the day. Dr. A responded warmly, outlining the surgical approach before explaining he needed an updated CT due to her hernia's progression. Her face dropped.

"What do you mean an updated CT?" she asked nervously.

Dr. A explained that operating with outdated scans would jeopardize her safety.

With a trembling voice, she asked "Are you saying I can't get the surgery? After all these years, I came here ready. I am ready. Why can't you use the old CT? I give you permission to use it."

Politely, Dr. A emphasized safety and his desire to help, and not harm by doing the surgery blindly.

"I'm not saying I won't or can't do the surgery. I am happy to do it—and I believe we can relieve your pain. But we need the updated CT first," he said gently.

Silence.

Tension started filling the room even with the door closed.

With tears rolling down her mask, she suggested a second opinion. Dr. A agreed, noting most surgeons would also require current imaging for her safety.

At that point, our patient – cheery and ecstatic 5 minutes ago - had shut down entirely. She was crying. Dr. A offered words of reassurance, but our masks created a chasm that even compassion could not bridge. I remained silent, unsure what to say, who to say it to, or when to say it.

The pride I had taken in myself slowly but surely shattered. I felt devastated. Here I was, just beginning my journey in medicine, already confronting its most difficult lesson: sometimes our best intentions are not enough. I tried to put myself in our patient's shoes—to imagine the courage it took just to leave the house for a CT, and then again for surgery. I felt a deep ache realizing she had used all her strength just to be here today. She had nothing left. The rational side of me knew the CT was simple and non-invasive, but the human in me saw it yet another mountain

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she had to climb. Still, the shame crept in, with that devil on my shoulder whispering, “It’s just a CT—it only takes an hour or two.”

She asked if she was free to go and leave the room, with tears filling up her mask.

Dr. A did not plead. He did not try to win her back. He simply let her go.

Back in the office, he debriefed with M and me. He explained his rationale again. He shared his frustration, his helplessness, and his wish to have helped her that day.

Finally, he looked at me and said “Sometimes you can do everything right as a physician. The books, the plans, the treatment, the backups. But still, you will not be able to help the patient the way they want. And there’s nothing more you can do.”

I carried Dr. A’s words with me for weeks afterward. In our preclinical years, medicine is presented as a series of problems with clear solutions—diagnose correctly, treat appropriately, and healing follows. But this patient interaction taught me that I can do all that right and still fail. This lesson—that sometimes there truly is nothing more I can do irrespective of my training hit hard — it was not in any of our textbooks or taught in classrooms, but it may have been the most important one I learned that year.

** Patient identity has been protected by altering identifying details while preserving the essence of the clinical encounter.*

24. Rounding with Zoomers: *A Reflection*

Julia Usatinksy, MD, FACP

Don't force your children into your ways,
for they were created for a time different from your own.

-Plato

I am officially old. Here is the definition of old age: your average resident is the age of your oldest child; your average student is the age of your middle child.

What about your youngest? Yes, the one who, when asked, first thing in the morning, how he is, mumbles with disgruntlement: "Tired!" "Why should you be tired?" I question, losing patience immediately. "You can't possibly be tired after a full night of sleep!" He looks at me with a gaze devoid of meaning, and his head drops back on the pillow.

After a stressful and chaotic morning, we make it to school with a minute to spare. I disburse my son in the parking lot and watch pairs, trios, and packs of kids walking to classes slowly, the noble and tragic expression of royalty being led to their execution on their faces.

I arrive at work a bit later than I planned. It may not be bad after all, I think to myself: at least my team will be ready for rounds, all their patients seen, all their plans thought out.

Not so fast. As I park, I get a text: "Hey Dr U we got stuck in orientation can we round at 9". My name is shortened to one letter. Punctuation is ignored. I sigh, and answer: "Yes, meet you on 3S at 9 am". "Thx", comes the laconic response.

I see some patients on my own. At nine sharp I am standing by the nursing station. My senior shows up at 9:02 at the end of the long corridor. He waves to me from afar and starts typing on his phone as he walks. "Texted team to come here now", he explains with an innocent smile.

Finally, my entire team is here.

"How is everyone today?" I ask.

"Tired," they respond. "Yesterday's call was very exhausting."

Well, if my 15-year-old was tired this morning, I admit, they certainly can be, too.

We dive in. A student presents first, and I am happy: he knows the case well. He finishes his presentation with the pronouncement: "Pretty straightforward case." I didn't find the case as straightforward as my student did, but sometimes the longer you practice, the more surprising twists you anticipate from even a simple case.

An intern presents the next patient. She starts by saying that the "vibe" from the patient in the room reminded her of her experience volunteering at a shelter for abused women. As she started exploring her patient's situation, she in fact uncovered a serious concern for domestic violence, and she already went ahead and consulted a social worker.

I am curious, and I ask my students and residents about their backgrounds. My intern worked as an EMT, volunteered at a shelter and a food kitchen, and travelled on a medical mission. My student taught at the Teach for America organization before medical school. My senior worked as a CNA at a psychiatric hospital and tutored math.

Their experiences are amazing. They have already accomplished more than I could have imagined. I guess their perpetual fatigue didn't really stand in the way of their achievements

As a student of natural sciences, I should be skeptical about psychohistorical theories that clump people into generational groupings and ascribe common qualities to them. And yet I am fascinated by these studies. Observing so-called Generation Z, and more specifically, young physicians from this cohort that have now started making it into the workforce, I can't help but notice their particular traits. And just like generations before me, I find myself and my colleagues sometimes expressing disappointment with our youngsters.

But every coin has two sides, as does every trait. Our zoomers are very concerned with their life-work balance, and with that, they are empathetic to their colleagues' and teachers' need for a break and support. They know how to exercise self-compassion much better than my generation, and are good at extending compassion to others. They are attuned to their own mental health and capable of recognizing when other people have emotional needs. They rely on technology from infancy, and learning and mastering all kinds of innovations seem like second nature to them (I am jealous!).

We finish rounds. Patients are tucked in, orders are placed, and consultants are contacted. By the time we are done, I am less inclined to buy into any theory of generational cycles. After all, we all seem to work toward similar goals: we try to do our jobs well, we hope to be able to help our patients, and at the end of the day, we want to go home to our families and have some well-deserved rest. Because we do get tired.

25. The Powerless Stage

Michelle Wafo, MD

I am a senior resident doctor. One who is increasingly allowed to make the final treatment plan for my patients.“Soon enough, you will be on your own,” I have heard repeatedly. Most of the time, I am excited about this. I feel stronger in most aspects of practicing medicine, from elaborating on differential diagnoses and setting treatment plans to communicating with families and navigating the healthcare system.

But! Pain is my weakness. The subjective nature of pain is one issue this Wisconsinite doctor (aka me) has a hard time navigating. I recently said bluntly to a patient, “Ma’am, I can’t prescribe you long-term oxycodone for this!”In the United States, up to 30% of older adults suffer from chronic pain. As an internist in training, I can confidently say that I have managed pain both inpatient and outpatient about 70% of the time. Fairly frequently, I run out of pharmacological/non-pharmacological options, and I end up with ‘what’s next?’ Or ‘what am I missing?’

Before I dive into my struggle with adequately assessing and managing my patients’ pain.I would like to go back to the younger me, the medical school version of me..

In medical school, we learned about different types of pain, from inflammatory pain easily managed with anti-inflammatories to the dreaded functional pain, such as fibromyalgia, which doesn’t have a clear-cut remedy. We have been taught how to manage acute vs chronic pain. It seems (at least for me) that we had a full shelf of medications and options we could pick from based on the nature, etiology, and chronicity of the pain. I remember my preceptor emphasizing weaning off opioids as soon as possible on the wards and carefully doing “risk mitigation” when prescribing pain medications in the outpatient setting. I left medical school feeling empowered about the management of pain, sometimes silently judging my attendings for taking too long to wean off a patient, or getting “unnecessary” imaging for a patient complaining of pain that I strongly believed needed more therapy than X-rays.

I have heard many times that medical training is a journey with multiple stages. One may call my medical school stage “ the simplistic stage,” in other words, the stage where, emboldened with fresh medical knowledge, most things can be fixed, especially something as “simple” as pain.

This stage abruptly stopped when I had my first panel of clinic patients as an intern; a simplistic illness script for pain was not getting me far. I had patients who had tried everything in the book and were still frustrated. Sending them to a therapist to deal with living with chronic pain felt like an utmost lack of genuineness, “I can’t figure out why you are in debilitating hip pain, go talk about your feelings with the therapist.” I later learned to refer to the pain management team or palliative care when stuck, which has relieved some of my anxiety, but has also been helpful for some of my patients.

“Some” is the word to use.

Over the past several months, referrals to more specialized teams have not saved me from the complexity of pain and its management. First, pain is deeply personal and subjective. I admit, I was taught to look at tachycardia, tachypnea, and increased blood pressure from baseline to clue me into the physiologic presentation of pain, but for anyone who has taken care of patients, it doesn’t take too long to find the above, useless in multiple instances. Second, pain is cultural; several studies have shown that black men requested less analgesics post-op than white-non-Hispanic counterparts, which in many instances, has been attributed to the stigma equating expressing pain to showing signs of weakness. As a black female, I could write an entire essay about the men in my life, who had suffered in silence due to the above stigma. Third, pain is usually multimodal; in the most affected patient, pain never fits in one bucket. Last, compared to the management of an infection, the management of pain can be strongly affected by the provider’s background, bias, prior experiences taking care of drug-seeking individuals..

I have appreciated the multiple subspecialty care teams available to help with patients’ pain. Nonetheless, as the primary care or the internist, I am usually the first person or the person they return to when everything has failed. And at such times, I enter my “ powerless stage”. At such a time, I can only be a friend, a fellow human who is faced with the limitation of medicine.

Maybe I care too much, as one of my friends told me. This is not about me, really; this is about the millions of Wisconsinites who struggle in silence in their home in pain. This is about the people around the world who have resorted to illegal drugs to manage their pain. This is about my godmother, who has been living with pain for as long as I can remember. It’s a meek cry out for more research to be done to not only find better analgesics, but also better ways to address and manage pain.

26. When Silence Speaks*

Jake Weiss

In the first week of my psychiatry rotation, I was assigned to follow "Dr. Arjun", a soft-spoken psychiatrist working in a rural community clinic. The waiting room buzzed with fluorescent light and the quiet shuffling of patients flipping through worn magazines. Dr. Arjun's calm presence stood in quiet contrast to the noise of the world outside.

One patient stood out immediately. "Maya" was a young woman who arrived each week but never spoke. She entered the room, sat down, and stared at the floor, her hands tucked into the sleeves of her hoodie. I watched, puzzled, as the minutes ticked by and Dr. Arjun simply sat with her. He didn't press her to speak. He didn't fill the air with therapeutic jargon or probing questions. After the session, he noticed my confusion and said gently, *"Sometimes, the silence is the session."*

I didn't understand. In my still-developing clinical mind, silence was a void to be filled—a sign that something was wrong. How could therapy work if no one was talking?

Over the next several weeks, I continued to observe their sessions. At first, nothing changed. Maya would sit in silence, sometimes for the full forty-five minutes. I found myself growing restless, resisting the urge to ask questions, to interpret her silence, to do something. But Dr. Arjun never seemed frustrated. He simply remained present—occasionally adjusting his posture, sometimes offering a glass of water, but mostly just being there. His attention was steady, but not invasive. His presence felt more like a quiet invitation than a demand.

One day, Maya arrived with a folded piece of paper in her hand. She didn't speak. She simply slid it across the table. Dr. Arjun opened it, read silently, nodded, and wrote something in return. She read his note, gave the slightest nod, and tucked both papers into her jacket pocket before leaving.

This became their new rhythm. Each week, they exchanged handwritten notes—brief, thoughtful, and private. The scraps of paper became a bridge. What began as silence evolved into a written dialogue. And I began to see what I had missed before. There were shifts happening, not in words, but in posture, breath, and the length of a held gaze. The silence was no longer empty. It was full—of meaning, emotion, and trust.

I began to realize that my discomfort with silence had more to do with me than with Maya. I had come to equate speaking with progress, talking with connection. But what I was witnessing challenged that assumption. In Dr. Arjun's stillness, there was attunement. In Maya's quiet, there was communication.

In psychiatry, we are trained to listen—but not always taught how to be with silence. There's a natural impulse, especially for a student, to fill every gap with explanation, reassurance, or advice. Silence feels like failure. But sitting in that clinic, I saw how silence can also be a form of respect—a way of saying, *I'm not here to push you. I'm here to hold space until you're ready*. Maya didn't need to be "fixed." She needed to be seen and accepted, exactly as she was.

As their paper notes grew longer, so did my understanding. I learned to observe more closely: a relaxed shoulder, a glance held a moment longer, a subtle smile at the end of a session. These were signs of healing, too. Maya's silence wasn't resistance—it was her language. And Dr. Arjun had learned how to listen.

This experience reshaped my understanding of communication in psychiatry. It taught me that connection doesn't always require words. Sometimes, presence is the most powerful intervention we can offer.

Silence can be a container—a space where patients feel safe enough to let their defenses down, at their own pace.

In underserved or rural settings like ours, where time and resources are limited, the temptation to rush therapeutic encounters is real. But Maya reminded me that healing cannot be hurried. Her journey required patience, adaptability, and the humility to meet her where she was—not where we expected her to be. The handwritten notes were a simple but profound example of how communication can—and must—bend to fit the needs of the person in front of us.

Looking back, I realize that the most profound moment in my psychiatry rotation wasn't a dramatic breakthrough or a clever diagnosis. It was sitting in a quiet room, watching two people write notes to each other in silence. One offering, the other receiving. A conversation, unfolding without sound.

On our final day at the clinic, Maya handed Dr. Arjun one last note. She didn't read his reply. Instead, she looked him in the eye for the first time and said quietly, *"Thank you."* It was the only word I ever heard her speak. But in that moment, it felt like a symphony.

That day, I finally understood what Dr. Arjun had meant: *Sometimes, the silence is the session*. And sometimes, it's where the healing begins.

** The identities of the patient and of the attending physician have been altered and de-identified to protect their privacy rights in accordance to the annals recommendations.*

27. Crying while sticking on EKG pads

Jessica Young, MD

As I skimmed through routine email at work, the subject line “Tiny Stories” caught my eye. One of the IM interns was requesting that faculty participate in a project that involved *“In 55 words, please tell a story* ***about a time in residency*** *that was humbling, stressful, relatable, rewarding, or difficult”.* I immediately knew what to write and was happy to have an excuse to avoid reading more mundane emails. The emotions of intern year are still so intense and vivid even after 28 years and my co-intern from that first month of residency is still one of my closest friends who I text daily. Here is the story that I shared:

It is 9 pm and I am the post-call intern in the VA ICU and still can’t go home because “back in the day”, you stayed until the work was done. My patient is on the vent and I am crying from exhaustion & hunger as I place the EKG pads on him since “back in the day”, we ran the EKGs. My BFF, who is on call, comes to help me get the work done, cheer me up and gives me a Snickers bar. Years later, she shares that story at my rehearsal dinner.

28. From Family Planning to Menopause to Dementia: A Reflection on 30 Years of Medical Practice

Laura Zakowski, MD, FACP

I knocked and entered the exam room. “June” was in her usual seat beside my desk, but this time her son was with her—an unusual occurrence. She was approaching a milestone birthday, and he had scheduled the visit, concerned about recent changes in her behavior. He had told me beforehand that she’d been interviewed for a local publication about her life, but had responded to many of the reporter’s questions with curt replies like “I don’t know” or “I don’t want to talk about it.” This was out of character, and the family feared a sudden onset of dementia.

I had known June for my entire career. She was around 70 when we first met—vibrant, inquisitive, and deeply engaged in her health. She asked thoughtful questions and was curious about my life, both in and out of medicine. She was healthy and independent, and I always looked forward to her visits. So, my first concern during this appointment was understanding why she had responded so uncharacteristically to the interview.

After 30 years in practice, I’ve come to appreciate how lifelong learning is not just about rare diseases or new treatments—it’s about evolving with my patients. Many of the women I began caring for in their 30s and 40s have aged alongside me, prompting me to grow in knowledge and empathy as they transitioned through life’s stages.

The Early Years: Family Planning

“Carol” was my age—about 30—when she came to see me. She hadn’t yet started a family and confided her fears about motherhood and balancing work and home life. She had recently been diagnosed with poorly controlled Type 2 diabetes. During residency, my clinic was at the VA, where I didn’t see a single female patient. So I dove into learning about pregnancy and diabetes, reading extensively and consulting colleagues. That approach—curiosity, humility, and collaboration—became my foundation as my patients and I aged together.

Another patient came in to see me with bloating and changes in bowel and bladder habits. She suspected irritable bowel syndrome and wanted to discuss treatment. She was new to my practice and had been using medroxyprogesterone acetate for contraception, so I initially glossed over pregnancy-related questions. But as I examined her, it became clear—she was pregnant. A Doppler confirmed a fetal heartbeat, and an ultrasound later revealed she was about 20 weeks along. She recalled being late for an injection. She eventually delivered a healthy baby boy and returned to see me postpartum. I reflected on my surprise—and her lack of it. That encounter reminded me of the dangers of premature closure, the importance of forming my own diagnostic impressions, and the need to remain open-minded, even when a patient presents with a confident self-diagnosis.

The Middle Years: Menopause and Chronic Conditions

“Mary” came in with a stack of clippings—articles about natural remedies for menopause, like soy and black cohosh. She wanted to stop her estrogen therapy and try something “more natural.” At the time, many of my patients were on hormone replacement therapy—prescribed by me—when the Women’s Health Initiative results were published (1), prompting a widespread reevaluation of treatment. I had recently presented at a national workshop on non-hormonal therapies and felt confident in my evidence-based stance: the data on botanicals was thin, and benefits were modest at best.

But Mary’s proactive approach challenged me. I had always encouraged patients to take ownership of their health, yet here I was, feeling at odds with her choices. This tension—between evidence and patient autonomy—became a recurring theme. And as menopause often coincides with the onset of chronic conditions, I found myself adapting not just my medical knowledge, but my mindset.

This phase of my career demanded a renewed commitment to diagnostic rigor, minimizing unnecessary testing, and staying open to evolving perspectives. It mirrored the adaptability required of patients as they age—and of physicians as they grow.

The Later Years: Dementia and End-of-Life Care

Back in the exam room, I wished June a happy birthday and asked about her celebration plans. She told me about the interview—how her son had arranged it, how she hadn’t wanted to talk about her life, and how she’d decided to be evasive. Now, she realized, her resistance had sparked fears of dementia.

Over the years, I’ve had the privilege of knowing patients deeply—caring for their family members, seeing them through life’s transitions. Watching a patient’s cognitive decline is heartbreaking, especially for their loved ones. When I asked family members, “How are you doing with all this?” the responses often came with tears, silence, or resignation. Sharing in that grief—bearing witness to the slow fading of a person’s intrinsic nature—has been one of the most profound aspects of my work.

To be part of my patients’ lives for decades, to grow alongside them, and to continually learn from them has been a privilege.

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The integration of long-term relationships, evolving medical knowledge, and the shifting demographics of my practice has kept me grounded—and always learning.

Reference:

1. Rossouw JE, Anderson GL, Prentice RL, et al. Writing Group for the Women's Health Initiative Investigators. Risks and benefits of estrogen plus progestin in healthy postmenopausal women: Principal results from the Women's Health Initiative randomized controlled trial. JAMA. 2002;288:321–333. doi: 10.1001/jama.288.3.321.

POETRY

29. Still Life at the Ice Cream Parlor

Mahmoud Awad, MD

PEOPLE'S CHOICE WINNER

I want to want nothing.
Not the sugar-slick gloss of it—
bright scoops behind glass,
flavors swirled like a child's dream
of summer, or mercy.
I want to sit with nothing
about the way
chocolate streams into vanilla,
carbs unspooling
like a secret too lethal to hold.

The boy behind the counter waits.
He's patient,
not like me, but the other kind.
The kind that doesn't feel
the slow hold of desire
pulling a body down and out,
like a tide.

I ask for water.
He holds it to me like it's holy.
No judgment,
no flinch. Just water.
Cold enough to sting.

Outside, a girl
drops her cone on the sidewalk.
Her father crouches beside her
and says something quiet
and kind.
She looks up, brave
and tear-slicked, nods,
lets him hold her hand.

I drink.
My hands don't shake.
I count my breaths
like they are wishes
I get to hold.

30. The Right Side of the Bed

Aisha Batool, MD, MS-CTS

Each morning began with numbers and charts—
Creatinine climbing, the urine too sparse.
Science was my solace, my shield, my role,
While grief curled quiet in the corners of soul.

I stood by his right, voice soft and sure,
“Good morning, Mr. Smith,” a ritual, pure.
Still intubated, silent in bed,
While hope hovered over the things left unsaid.

She’d be there too—his steadfast wife,
Wearing kindness like breath, holding on to life.
“He did well before,” she’d say, eyes bright,
Belief gleaming through each long night.

CRRT hummed its steady refrain,
As his marrow failed him again and again.
And I — a healer, or so they say —
Held her a little longer that day.

She crossed the street in dawn’s first hue,
And I thought, What a kind human, true.
Later, her hug, fierce and tight,
Told me she knew the end was in sight.

When I spoke the truth, she cried so still,
Her silence louder than sorrow’s will.
She held my hand, a napkin, then—
Touched my back, like an old, dear friend.

A painting pressed into my palm,
Born from a 4 a.m. balm.
“Thinking of you brings peace,” she said.
My tears spoke what I left unsaid.

We said goodbye without saying the word—
In that silent room, everything was heard.
Now, in moments when hope feels thin,
I trace that painting, and breathe her in.

For we, the healers, carry unseen scars,
Lit not just by science, but patient stars.
They remind us, when we start to fall,
That love, even small, heals us all.

31. For Her History

Corey Briska

For it was her history, her grace, her lively showmanship.

I knew her to be special, one who would appreciate the finer attire draped across a young comedian.

Her love of worldly affairs in which I would make no comment. Nevertheless, the kindness was always there at the bedside. Was it that she was born into this state or acquired?

With work and dedication Or with no effort at all?

I have to recall myself, how the pleasantries formed? From stone molded into Michelangelo's David
Perhaps from the teachings of Rene Magritte?

No matter, I felt safe and loved.

How was it that I, the carer, the steward of time, organization, administration, and the unknown learned from the observations she made?

Experience seems to be the teacher of all things.

Although she tended to forget that. I remember. I always do.

She had the experience and needless to say, she did not have to remember that. It's a notion. An idea. Meaningless, really.

The cadence, the history, the introspection is what really mattered. She unconsciously held them.

When she looked to the ceiling with nothing but a smile and a lifeless pulse, experience truly became the teacher of all things.

32. The Wise & The Fool

Michael Esson

Curses swirl and hurl all around her,
Vile breath and venomous tongue whirls around her, as if the sun around the world,
Hate lingers in eyes that pierce, vanishing shadows of whispers unfurl,
All the while, the girl in the asylum stands strong, hands on hips,
On her pierced lips, a defiant grin, time in her grip.

A thousand tear drops fall from her gaze,
Swift like gossip, her smile beams a thousand sun rays,
Bare feet embrace the cold caress of the earth beneath,
She studies the encircling walls: a glass front, a T.V forever replaying an endless sitcom, and me — standing on the east,
Bathe in her glow, I'm entranced in fascination,
Her gaze intense, delves into my thoughts, sparking revelations.

Innocence blooms in her embrace, a hint of black from her sweater on my palms,
Thin, dark curls soothe my shoulders calm,
Her smile reveals teeth with a touch of yellow, like a golden pearls' reflection,
And in a whisper, she says "I like you, because you don't dress fancy", a heavenly connection.

33. Did She Smoke?

Amber Haugen

The day before you died
I asked if you were scared
“My life is almost over,
But the memories we share.
You’ll become a doctor,
One who really cares”

So that’s just what I did
I’m set to graduate in May
It’ll be four days post my birthday
And five past Mother’s Day

I’ll place your favorite flowers
Next to your ashes in an urn
For we couldn’t afford the burial
That you and I deserved

When others ask your cause of death
I’m hesitant to say
For the most common response is
“Did she smoke?”
As if that makes it all okay

Your better habits won’t save you
From what’s written in the stars
No matter how good a person
We all leave this place with scars

Whether it’s food
Or alcohol
Or reality TV
We all have vices that we hide
To quash anxiety

34. More Than Memory

Maggie Holmes, MD

His jacket worn, a cap with stitched brigade,
His stories fragmented, only recalling his name.

His hands reached mine - both withered and kind,
And gifted a leather pouch, worn soft by time.

Inside lay photographs, lives in fragile frames,
Though details blurred, love and warmth remain.

A woman in white, sun illuminating her veil,
Twin boys in motion along a wooden trail.

A sunlit boat, old friends lifting cheer,
A retriever whose companionship lingers near.

His words now faltered, yet images see,
A man whose past still glows with dignity.

I listened, not as a doctor, but as a guest,
Felt one of life's meanings expressed.

Though minds may drift like tides pulling away,
Untouched by illness, the spirit will forever stay.

35. Learning to Swim

Kaitlyn Jackson

In the stillness of water, I've always found peace,
The waves whisper softly, my mind's quiet release.
But when I've stepped in, my feet left the ground,
A fear held me captive, where confidence drowned.
Years have passed, but the pull never ceased,
The call of the water, the yearning for peace.
Now, in my last year of this medical fight,
I choose to embrace what once caused me fright.
I'll face my fear, take the plunge with grace,
It's never too late to learn in this space.
Whether it's swimming or chasing a dream,
The time is now, let your courage gleam.
So I call upon friends, and those who believe,
In the power of trying, in what we can achieve.
Let's dive into life, and learn to swim—
The world is wide, and the journey's ours to begin.

36. *Through The Eyes of a Resident...*

Shikha Jha

An ongoing splendid journey, sparkling fire in my fierce eyes Marching
through steppingstones, always ready to shine and rise Very little do I
know about the upcoming challenges ahead Terrific enthusiasm within
my soul, roaring loudest in my head

Exploring the art of medicine and the sagacity of mankind So much I
am learning through days, nights, grill & grind Not a single day of mine
passes without self-awareness
The highs drive me forward, the lows add more humbleness

I know I am not perfect, neither will I ever be
Not aiming perfection, my best version is all I want to be So much I
want to do of all, so little time do I have in hand Learning to soar higher,
not bothering where would I land

Remembering those days when I shed tears during my setback Self-
doubt and fear of failure made me think of things I lack I realized the
beauty of being an empty jar during my training
Abundant knowledge & experiences I get to fill, as if it was raining

Mistakes I make time and again, I am learning through them all Joyous
victories boost my confidence, does not matter, big or small What really
counts is, my thoughts of appreciation and gratitude Let odds knock
me down, still I rise with "never give up" attitude

Grateful I am dear almighty! Chosen I am to care & serve Not a single
day do I take for granted, my zeal I opt to preserve No matter how tough
journey gets, tougher & stronger I shall be
Ferocious are dreams, perseverance & humility will write my destiny

37. Some Things I Cannot Provide

Harshitha Mogallapalli, MD

Another appointment I'm not looking forward to
and neither are you

I wish I knew what was causing your pain
I read and read and searched in vain.
No, I don't know what is causing your pain.

Here's a pill.
Here's a pamphlet.
Here's a support group.

I'm dreading opening your door.
How are you?
"good" you whisper.
Not sure if it is true.

I sit down.
Your eyes downcast.
Anything new?
Nothing to hold our hopes to.
You keep taking it day by day.
I am proud of you.

Inside my head rush the million things I wish for
But there are many things I cannot do.

We are called providers because we are meant to provide.
But sometimes I cannot provide the answer
I cannot provide the cure.
I cannot provide the safety.
I cannot remove the scars, neither inside nor out
I cannot stop the growth nor slow the spread.

I cannot bring your daughter home.
I cannot change the cards you've been dealt
No matter how much I wish I could

Your stoic nod says it all
You say it's not my fault
I know. But I'm still sorry.

But I will be here
To ease the pain
To do everything I can

Maybe I can hold your hand and tell you I am here by your side
No more tests, no more scans, nothing to pick up
But here I am
Maybe that's all I can provide.

Author's Statement: There are times when the word "provider," brings with it feelings of helplessness and frustration. This is not inspired by one patient encounter, but by many. I wanted to illustrate the journey of a patient and provider who are transitioning from finding cures to focusing on quality of life and less invasive measures. I reflected on how we might not be able to provide exactly what the patient wants; a cure or an explanation, but there are other things we can provide; accompaniment and understanding.

38. You, or Someone Like You

Connor Pedersen, MD

JUDGED WINNER

ACP American College of Physicians Leading Internal Medicine, Improving Lives | Wisconsin Chapter

POETRY: *RESIDENT*

When I ask where you're from,

I'm really asking who you are.

It's open-ended, open-handed, a two-way invitation. We're both uncomfortable here.

This hospital room, with its bleached-bone sheets and arrhythmic birdsong, is new to you, but achingly familiar to me. It reminds me of its sister, two floors up and three doors down.

On the left.

You, or someone like you

Grew up on a small farm just outside the city, among many brothers and/or sisters. Your father was distant but your mother was warm, or the other way around. You grew *wheat-barley-rye* and never complained about how little of that touched your plate.

There are calluses on your hands and feet and heart, where barbed wire and red meat left their mark. You complain about various small things but not when I touch these.

You, or someone like you

have arteries turned to stone, a heart meshed with cobalt and steel.

You, or someone like you

are a sixteen-year-old boy in an empty room. You are being seen by gastroenterology (*stomach doctors*, I add), because that might be where you're losing blood. It's much easier to hide bleeding when it's inside. Pallor is harder to see on darker skin.

I spend an hour asking questions and trying not to fiddle with my hands, taking detailed notes as you speak through a glaze of anemia and youth.

You, or someone like you

are from a rough part of town and your parents work multiple jobs. Your brother has cancer and it has metastasized into your life. You've been nauseous, dizzy, fainting for months but never told anyone. Today, you finally fell hard enough that someone noticed.

I return to the *stomach doctors* with your story. They say the patient (*you*) will be discharged from their service because it doesn't sound like a stomach problem.

You, or someone like you

hate Florida, your broiling birthplace. You hate the mosquitoes and the humid air and the heat-haze that radiates from your parents. You define yourself the same way your heart defect does. By the location of its emptiness, of what was never there. The absence of growth.

You, or someone like you

are shaped by dreadful cyclicity; that twist of blood vessels that loop back in on themselves, like the highways of your hometown where the people try to leave but always come back.

You, or someone like you, were

a missionary in Ethiopia, hands passing out bread and bibles

a teenage girl diagnosed with an anxious mom and allergies

a schizophrenic with seven supposed birds

a paramedic who leapt from helicopters

a fellow insomniac

a man with a razor in his wallet between myself and the doorway

You, or someone like you, are

a study in unraveling

a glacial mourning

a tree branch worn smooth by the Pacific

You, or someone like you

were diagnosed with Alzheimer's at age 55, and told me while we were eating ice cream downtown.

39. Learning to Hold a Hand I Couldn't Touch

Jake Weiss

In the spring the sirens didn't stop, and I was still learning—
a student CNA
suddenly assigned to the COVID ICU, where even comfort
came second to survival.

We wrapped ourselves in masks, in gowns, in fear—
watched rooms fill faster than they emptied, watched families disappear behind phone screens or not appear at all.
No visitors. No hands held. No goodbyes.

I learned to hold a hand I couldn't touch— not with fingers,
but with voice.
Wrapped in plastic and protocol, I stood at bedsides like a shadow pretending not to shake.

She was one of many,
an elderly woman, alone— oxygen hissing, body frail,
skin gray with the weight of days spent fighting. Her chart said Do Not Resuscitate.
Her room said: No one is coming.

The nurses rushed past,
chasing codes and crashing stats. And I—just a student—
stood still.

There was nothing in my training about how to say goodbye without a hand to offer.
But I stayed.

Her name was written on her wristband, but I read from deeper lines:
a daughter, a sister,
a lover of peaches and crossword puzzles, a woman who once danced barefoot
on a kitchen floor.

I spoke her life aloud
as if naming it could keep her anchored— listing her children
like saints, her stories like scripture,
her chart like a prayer
I wasn't sure how to end.

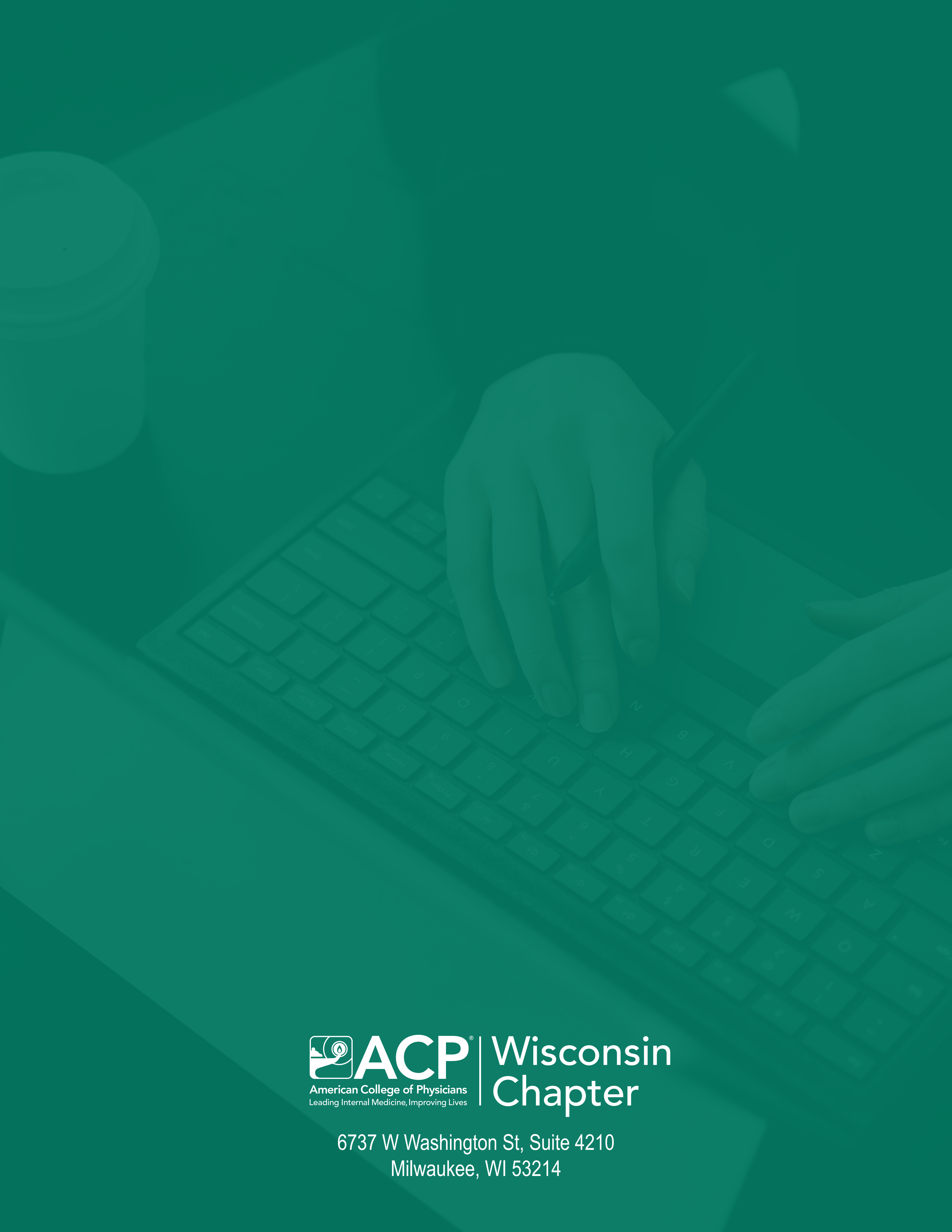
The mask hid my trembling lips.
The gloves muted the warmth of my skin.
The walls sealed us off
from the world she was leaving
and the family she'd never see again. And yet,
in the quiet of that room, she was not alone.

I had nothing to offer but presence—
a silent vigil
for a stranger whose absence would echo through the halls long after the machines went still.

No textbook taught me this: how to comfort with a chart,
how to mourn behind a face shield, how to witness a life
without laying a hand on it.

But medicine lives here too, in the space between breaths, in the dignity of being seen, in the soft and sacred act
of not turning away.

Even now,
I don't know if she heard me. But I do know—
when the world locked its doors and love had to find new forms—
I learned to be the hand she could not hold.



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